APPRAISAL, COPING AND INITIAL PSYCHOLOGICAL OUTCOME IN SEXUALLY ABUSED CHILDREN

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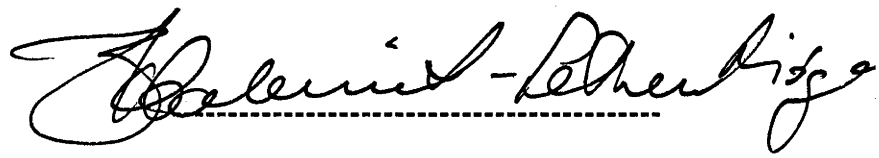
STATEMENT

This Thesis contains no other material offered for the award of any other degree or diploma, or the material previously published, except where due reference is made in the text.



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ABSTRACT

The purpose of the present study was to examine the role of cognitive appraisal and subsequent coping style in determining the initial psychological effects of child sexual abuse, and in doing so, investigate the factors that lead to better or worse adjustment among children who have experienced sexual abuse. The present research question is new amongst Australian literature and empirical investigation. It is important to be aware of the exploratory nature of the study, and to recognise it's role in prividing a base for future empirical research. Fifty two female and male subjects, aged between 7.5 and 15 years, participated in the study. The 'abuse' group consisted of 26 Ss who had experienced intra-familial or extra-familial sexual abuse up to 18 months prior to the study, and had begun counselling. The control group was matched in age, gender and family constellation, and consisted of 26 Ss who had experienced a significant stressor in the 18 months prior to the study. All Ss completed the Children's Depression Inventory and Ways of Coping and Appraisal Checklist. Therapists (for the 'abuse' group) and parents (control group) completed 'Historical and Demographic Information Questionnaires'. Correlations and Multiple Regression analyses showed that sexually abused children who perceived the abuse as involving stigma, coped by distancing or detaching themselves from the situation, and those who perceived the experience as involving loss, did not use problem solving to deal with the situation. The abused group's stress appraisal was significantly higher than the control group, as was their self - reported level of depression. The abused group also made more appraisals of self blame, loss and stigma than the control group in relation to their situation. However the abused group's ways of coping were not related to depression. Overall, the factors associated with variations in depression scores were whether the child had been sexually abused, and the use of Distancing and Accepting Responsibility to cope with the stressor. Results lend support to the stress - coping adjustment paradigm, however indicate the importance of further work to delineate specific mediating cognitive factors in accounting for the variability of effects of child sexual abuse.

INTRODUCTION

Conte's research (1987) on variables associated with an increased impact of Child Sexual Abuse (CSA), leads them to make the following recommendations: "The findings point to the importance of *understanding the victim's experience of the abuse...variables such as the victim's perception of her own role in the abuse... appear to be related to the effects of sexual abuse. These and other variables such as those describing the victim's coping during the abuse suggest that future research and clinical work should make use of information from victim's themselves...*" (p. 210).

The purpose of this study is to examine whether or not children's cognitive appraisal and subsequent coping with childhood sexual abuse mediates psychological outcome. Despite vast empirical research documenting the deleterious effects of child sexual abuse, (Browne & Finkelhor, 1986; Russell, 1986; Hotte and Rafman, 1992; Kinzl and Biebl, 1992; Murphy et al, 1988, Briere & Runtz, 1988; Chu & Dill, 1990) the literature raises questions about factors directly influencing the variability of these effects in children. The majority of empirical research on CSA has examined "abuse variables" (eg., severity and type of sexual abuse, frequency and duration, perpetrator) as being responsible for post sexual abuse symptoms (eg., anxiety and fear, depression and suicidal ideation, low self esteem, personality disorder). However due to lack of control groups, standardised objective measures, and confounding independent variables, ambiguity exists as to which effects may be directly attributed to the abuse variables, and which may be related to prior, concomitant or post abuse factors such as family pathology, physical abuse, post-disclosure reactions from significant others and intervention from institutions or agencies.

As Stovall and Craig (1990) state: "The controversy between researchers who argue that it is abuse per se vs those who argue that it is distress in the family that results in

impaired psychological adjustment, underscores the *need for a description of the internal world of abused children..." (p 241).*

The literature indicates that most children are profoundly traumatised by CSA, some exhibit moderate or transient problems, and a small percentage appear not to have been immediately affected by the abuse. (e.g., Constantine, 1980; Brown and Finkelhor, 1986, Herman, 1981; Murphy et al, 1988). Emerging from the literature is an important area which has been omitted - the empirical investigation of children's own beliefs, perceptions and thoughts, and how these might contribute to the varying effects of CSA. Unfortunately, as Rutter (1984) claims, the whole area of the stress, coping and adaptation is limited by the lack of research including children.
A further issue being examined in the study are the "external" variables that may moderate the impact of child sexual abuse, such as duration, frequency and type of abuse, events surrounding disclosure, and relationship between perpetrator and child.

The current research is based on the cognitive-behavioural literature on stressful events, appraisal, coping and behaviour (Folkman & Lazarus, 1984). The author will firstly define and present the theoretical model of stress, appraisal, coping and adjustment, briefly discussing developmental literature, and based on a number of research findings, apply this to children. This will be followed by a literature review on the effects of sexual abuse on children, including demonstrated factors that potentially mediate or influence the impact of child sexual abuse on children, such as social support, quality of child-perpatrator relationship, severity of abuse, 'resilience' of the child, gender differences and frequency and duration of abuse. As Conte and Schuerman (1987) indicate from the results of their research: "To be able to design abuse sensitive interventions, ie., treatments that deal directly with the problems of living that are associated with abuse while the victim is a child, before those promlems appear in adulthood, a new area of research is needed...will need to identify the mediators between abuse and abuse related experiences..." (p. 388).

Despite the plethora of literature demonstrating that child sexual abuse is a significant stressor for a dramatically increasing population of children, and has in the majority of cases damaging effects (eg., Murphy, 1988, Hotte & Rafman, 1992) little, if any, research has been directed toward determining the specific coping methods children use in attempting to handle the stress. The present research was conceptualised in 1989. To date, one research study, conducted in the United States by Johnson and Kenkel (1991) addresses appraisal and coping strategies used by children who had been sexually abused. Their results will be used as a comparison for an Australian sample.

The significance of the present study is:

1) To date, there is no available quantified information, based on an Australian population, on how children perceive and cope with CSA. Research examining how some children are able to cope in a way that reduces the negative and often profound impact of CSA, enables professionals to understand and help children who are referred for therapy, in a way suited to that individual's needs and current functioning. "Given that 20 to 40% of sexually abused children display clinical problems immediately after the abuse (Tufts New England Medical Centre, 1984) it is important to determine which variables are associated with little, moderate, or severe trauma, and to ascertain the type and extent of injuries suffered by the child. Such information allows a prognosis to be formed and provide a basis for subsequent treatment procedures" Basta & Peterson (1990), p. 555.

2) Comprehensive understanding of coping behaviours and effects of CSA assists in the investigation and validation of CSA: not all children show traditional indicators (eg., Powell, 1991). Clinically, the presence of psychological or behavioural problems should never be regarded as evidence that abuse has occurred in a particular case. Although abused children display a significantly higher rate of behavioural and emotional problems than children of nonproblem families (Browne &Finkelfor 1986;

Conte& Schuerman, 1987; Friedrich, Bielke &Urquiza, 1987) so do other children from stressful but non sexually-abusive home situations.

"...21% of the sexually abused children have none of the symptoms thought to 'prove' that a child has been sexually abused...Hence, those who are charged with determining if a child has been abused should not place undue reliance on a child's behaviour as proving what experiences the child may or may not have had" (Conte & Schuerman, 1987, p.209). Clinicians cannot assume that a child was traumatised because she/he was sexually abused, neither can we assume that a child who displays no indicators is well adjusted in response to the CSA. Thus an understanding of the child's possible belief system, perceptions, attributions and subsequent coping in response to having been sexually abused, would assist in providing a necessary framework for assessment.

LITERATURE REVIEW

1. *COGNITIVE VARIABLES: APPRAISAL AND STRESS*

1.1 *Lazarus and Folkman's Theoretical Model*

The approach used in the study is based on the theoretical model that individuals will appraise and attempt to cope with a stressful event, and these cognitive processes will influence the outcome of the stressful event. According to this model of stress posited by Lazarus and Folkman (1984), the appraisal of a stressful event and the ways of dealing with it, more than the actual event itself, determine a person's emotional and adaptational adjustment. Cognitive appraisal research was developed by Neufeld (1975), Breznitz (1976), and Lazarus and Folkman (1980) to name a few. Lazarus and Folkman (1984) suggest that two kinds of cognitive appraisals take place

before coping strategies are utilised: Primary appraisal is the initial cognitive response to an event - the individual assesses what is at stake, and if the appraisal is one that threatens her/his wellbeing or not. The following step is Secondary appraisal, which consists of the person's conceptualisation of the implications of the event in terms of coping options, i.e., what can be done to manage the situation. Both appraisals, of assessing what is at stake and determining coping options, interact with each other in shaping the degree of stress and the strength of the emotional reaction. Secondary appraisal is a crucial feature of every stressful encounter because the outcome depends on what is at stake and on what can be done - if the person is helpless to deal with a demand, stress will be relatively great because the harm or loss cannot be prevented or overcome. This point is important when considering appraisal of sexual abuse, as children in the pilot study revealed that there was nothing they could do to stop the *occurrence* of CSA, although they could stop or modify the way they thought and felt about it. The researcher's question then becomes how children coped with *this* fact, rather than the fact that they were being sexually abused.

Lazarus & Folkman (1984) describe 3 types of primary appraisal: Irrelevant, i.e., no implications for the individual's well-being - she/he has no investment in possible outcomes, thus there is no value placed on the event; Benign or positive, i.e., if the outcome of the event is construed as harmless or positive, and Stress appraisals.

Stress Appraisals: Harm, loss, threat and challenge

Lazarus and Launier (1978) originally proposed that an individual can construe an event as a loss or harm, a threat, or a challenge (given it is not irrelevant or benign), and it is the individual's interpretation of the event that initiates a particular set of coping reactions and strategies.

1) A loss is defined as harm or damage already sustained to the person, e.g., debilitating injury, loss of a valued person, recognition of some damage to self and/or social esteem. Lazarus &Folkman (1984) describe the most damaging life events as

being those in which central and extensive or all encompassing commitments are lost. Behaviours associated with the loss appraisal are characterised by fear, anxiety, anger and depression - which are also the documented effects of CSA (eg., Browne and Finkelfor, 1986; Chu & Dill, 1990).

2) Threat appraisals concern harms and losses that are expected, (e.g., in CSA, the threat of loss of a trusting and protective relationship with the offending caregiver, threat of child's well-being, threat to the integrity of a child's body and self, eg., Finkelhor, 1987) and permits anticipatory coping.

3) Challenge appraisals can also be threats, however their focus is the potential for gain or growth and excitement. The cognitive difference from loss is that of mastery and self efficacy. Challenge appraisals are more likely to occur when the person has a sense of control over the relationship or situation.

A study by McCrae (1984) showed that types of coping responses in adults were correlated with types of appraisal - they attempted to assess the influence of losses, threats and challenges on the choice of coping mechanisms. They found that type of stressor had a consistent and significant effect on the choice of coping mechanisms : faith, fatalism and expression of feelings were used especially when subjects had experienced a loss; wishful thinking, faith and fatalism were used by subjects facing a threat. A number of mechanisms were used more under conditions of challenge, including rational action, positive thinking, restraint, perseverance, drawing strength from adversity, intellectual denial and humour.

1.2 ***Children's Appraisal of Stress and Attributional Style***

Research findings tend to support the proposition that an individual's attributional style influences how she/he responds to life events (Rutter & Garmezy, 1984), however little research in this area has been undertaken with children. Many studies have conceptualised stress in terms of events that cause change and require some degree of

coping and adaptation (Johnson, 1982). It appears indisputable that children experience considerable stress and that a wide range of negative consequences can follow. Children's response to stress is highly varied, and as with adults, children's interpretations of a stressful situation affects their response to it (Rutter 1983, 1985). As Rutter and others point out, different children may define the same event as irrelevant, benign or threatening - a child's subjective appraisal of stress plays a larger role in determining response than does the stressor itself (Lundberg,1986). " It is not the event itself, but the child's experience of it that is important" (Wolff, 1981, p. 17). Efforts in recent research therefore have been directed towards identifying why some children cope with stress more successfully than others. With this information, researchers and practitioners are in a better position to to help children cope more successfully with the stress they inherently encounter.

Kyrios and Prior (1991) and Rutter (1985) discuss individual contextual characteristics such as adequate social supports, satisfactory relationships, and adequate child-rearing practices as mediating the effects of stress in children. For instance, while children of a clinically depressed parent have significantly more emotional, somatic, and behavioural problems than children of a non-depressed parent, the general family environment has been found to mediate the effects of parental depression on child adjustment (Billings and Moos, 1983). With the majority of stressful life events (CSA, sibling death, divorce) it is the disruption of family functioning eg., broken parent-child relationships, that causes emotional disturbance, rather than the incident itself (Rutter, 1981). One of the most commonly found factors associated with with the development of serious emotional problems in children is a disturbance of parent-child relationships (Masten and Garmezy, 1985; Dunn, 1985). Johnson & Kenkel (1991) found that the most powerful threat perceived by sexually abused children was the break up of the family. CSA research shows that children who deal with CSA effectively experience positive parent relationships, as opposed to children whose parents neither believe or support them during and after disclosure (eg., Johnson & Kenkel, 1991, Browne & Finkelhor, 1986). It is then important to consider appraisals that encompass threat or loss when dealing with

CSA, as not only is the child dealing with the abuse, but of fears regarding stability, security and predictability of the family unit. This was confirmed by interviewing subjects in the pilot study about the "worst thing" about their experiences of CSA.

Furthermore, child characteristics such as gender, temperament, and competency (and sense of mastery) may mediate the effects of environmental stressors such as marital rivalry or discord (Garmezy, Master & Tellegen, 1984; Porter & O'Leary 1980). Children who exhibit social and interpersonal competence and high intelligence have been found to overcome the effects of a stressful family and social environment (Garmezy et al.,1984). These studies have been conducted to identify conditions and variables that mitigate the effects of stress in some children, and exacerbate it in others. Factors such as developmental level, - as children's perceptions, interpretations and coping abilities change with their development - (Maccoby, 1983; Garmezy, 1985), temperament, including "resilience" characteristics, parental coping skills (modelling), parental support, gender and intelligence have been shown to mediate the effects of distress in children.

Perception of control when appraising a situation is a significant factor. If a child feels she is at the mercy of fate, she is far less likely to develop successful coping strategies than if she feels she has some control over her destiny (Rutter, 1985). Also, multiple and repeated stressors are more likely to overtax a youngsters coping abilities (Sterling, 1985). In particular, the concept of temperament has been proposed (over the years) as a possible explanation of individual differences in susceptibility to stress. Appraisal and coping research that underscores individual differences in children experiencing adverse situations include Werner and Smith's (1982) studies on children growing up in alcoholic families and Zimrin's (1986) study on physically abused children. Both studies show that despite equal environmental demands on these children, psychological outcomes differ. Children who "survived" their situation perceived and coped with their experience differently to children who became maladjusted. The cognitive processes that intervene between the situation and response, - the appraisal of the event - is a significant factor in determining a child's adjustment to adverse circumstances.

1.3 ***Cognitive Appraisal and Depression***

Depression and appraisal will be discussed within two areas: 1) perception and experience of loss, 2) cognitive representations of sense of self:
Firstly, Garmezy and Rutter (1985) suggest that it is useful to differentiate personal losses from other types of life event because of the mediating role of grief and because of the particular link with affective disturbance. Losses appear to be the events most closely associated with the onset of depression in adults, and although this is not empirically clear in children, it is known that personal losses tend to be traumatic at any age (Rutter & Hersov, 1985).

The second point pertains to the sense of self playing an important part in affect and behaviour. Much of the research has focused on delineating the role of cognitive processes in determining affective responses to stressful life events. (Zupan, Hammen & Jaenicke 1987; Johnson and Miller, 1990). A cognitive-behavioural framework of depression, as applied to children by researchers Hammen & Goodman -Brown (1990), includes children's cognitions about representations of their senses of self that are oriented around particular kinds of experience, and stressful life events that are hypothesised to have differential impact on children, depending on their cognitive susceptibility. This framework adopts a self- schema approach to depression vulnerability (Beck, 1982; Cicchetti & Schneider-Rosen, 1986). The schema measure is based on the assumption that enduring mental constructs organise, guide, interpret, and retrieve information about the self in memory (Markus, 1977). Hammen & Goodman -Brown's (1990) approach hypothesises that many high risk children acquire negative perceptions of their worth and competence. *Negative events that occur in the childrens lives that are interpreted as especially meaningful to their sense of self may be viewed as further depletions of the self, which the child feels incapable of resolving effectively.* This sense of helplessness and worthlessness are the depressive reactions to interpretations of personally meaningful life events and circumstances.

Hammen & Goodman-Brown (1990) hypothesise that *events are associated with depressive reactions to the extent that individuals construe them to represent a diminishment of the self - a loss, failure, evidence of inefficacy or depletion* (as relevant to CSA). They classified subjects as "interpersonally vulnerable" or "achievement vulnerable". Ninety percent of the children in the depressed group were classified as having interpersonal schemas - the impact of interpersonal events may be especially marked for children with interpersonal vulnerability. Hammen & Goodman-Brown's (1990) conclusion indicates that children, like adults, interpret their experiences in terms of meaning to their feelings about self worth and self efficacy. Stressful life events, for eg., may be construed as depletions, leading to depression, or as largely irrelevant and therefore only temporarily distressing. The meaning attached to an event depends on the content that is especially relevant to self-definition.

This is significant with regards to sexually abused children's appraisal of self blame and perception of loss and damage, as well as social support after disclosure. A number of studies suggest that the experience of CSA reduces the sense of self worth and self-esteem in the victim (eg., Bagley and Ramsey, 1985, Herman, 1981, Oates, 1985). Finkelhor and Browne (1987) link this with the process of internalised negative evaluation and "stigmatisation" that occurs within a sexually abuse experience. This leads to feelings of unworthiness, shame, and depression which in a large number of instances becomes overt in the accompanying behaviours of self-destruction and suicidality (Briere and Runtz, 1986). Depression as a consequence of CSA has been theoretically associated with the inherent process of powerlessness, stigmatisation and betrayal (Browne and Finkelhor, 1987).

1.4 *Appraisal and Sexual Abuse*

Attributions to victimisation are significant regarding outcome, i.e., causal interpretations by victims as to why the event is happening to them gives insight into potential psychological outcome. For example, "a component of the experience that may influence feelings of powerlessness are children's attributions and their evaluative interpretation of why they were victimised" Wyatt, (1987) p 404. (This again is relevant to 'meaning'). Attributions of control appear to lead to lessened long-term stress reactions to the event (Bulman & Wortman, 1977). Control with CSA is not necessarily expressed in the way we may expect, eg passivity may be the child's attempt at coping and maintaining control. Consistent with Peterson and Seligman's theory on victimisation and Learned Helplessness theory, (Seligman, 1975) causal attributions that are internal ('I deserve this b/c I'm no good') stable (a personality characteristic is seen as "fixed") and global (the cause, 'my being no good'), are an appraisal process that empirical research has shown to be responsible for individuals explaining bad events (Peterson et al., 1982) and consequently developing characteristics of learned helplessness i.e., passivity, emotional numbing, depression, loss of self esteem (Pasashow, 1980; Golin, Sweeney & Shaefer,1981; O'Hara et al., 1982).

Related to appraisal of abuse are "variables such as the victim's perception of her or his own role in the abuse, or the victim's perception of the overall quality of her/his relationship with the offender do appear to be related to the effects of sexual abuse". (Conte & Schuermann, 1987, p 210). Also, as Gelinas (1983) suggests, a common attribution made by CSA children is to lessen the significance of the meaning of the event. e.g., "It's not really a problem because he's only my stepfather, not my real father", ie., to deny the importance. According to Gelinas (1983), this thinking may lead to denial or emotional numbing as coping. Research points to this strategy being effective in reducing trauma in the short term, however dysfunctional in the long

run (e.g., Briere & Runtz, 1987; see section 2.3 "Avoidance coping" for further review).

Research by Girelli et al., (1986) suggests that the *degree of threat* involved during a sexual assault may be more closely related to the degree of distress suffered after the assault than is an objective measure of the assault's severity. The child's perception, such as whether she feared physical injury, whether she thought the family would break down, whether she she felt betrayed, is perhaps more likely to predict psychological functioning than determining how physically intrusive the abuse (Murphy et al., 1988). As Steele (1986) writes, in the context of physical abuse: "Damage comes when the injuries are inflicted by those to whom one looks for love and protection, and their is no relief from trauma. The same is true of sexual abuse...it is not the simple sexual act itself...it is the psychological emotional setting in which the sexual maltreatment occurs, and with whom it has occurred that makes the difference and causes lasting damage" (p.284).

Johnson and Kenkel (1991) examined the role of appraisal and coping in adjustment of adolescent incest victims. Their study demonstrated a clear relationship between the incest victim's appraisal and coping strategies and her psychological adjustment. This has a different emphasis or focus to previous research in the area, for example, Finkelhor (1979) and Seidner and Calhoun (1984) found that variables such as frequency of abuse, use of physical force, duration, age of victim etc., are significant in determining experienced trauma and effects. Johnson & and Kenkel's (1991) study did not support the view that characteristics of the victim, offender and abuse play a major role in the victim's post-disclosure adjustment ; rather the results support the significance of perception or appraisal of the event and subsequent coping variables, compared to other factors. This confirms research findings from Weiss (1971) and Lazarus and Folkman (1984) that a person's response to the stressor is often more influential than the actual stressful event in producing psychological maladjustment.

The findings of Johnson and Kenkel (1991), as related to appraisal are as follow:

- The more the incest victim appraised her stressful event as threatening (feelings of danger, worry, fear and nervousness), the higher her level of distress.
- This was specifically correlated with her experiencing a lack of control and volition: "feeling she has to hold back from doing what she wants to do" was related to higher levels of distress.
- Adolescents who were upset by their mothers reactions post-disclosure reported greater overall distress. Familial support was shown to be crucial in aiding an adolescent's recovery after CSA (as in Burgess and Holmstrom 1978).

Johnson & Kenkel's (1991) findings confirmed the common sense expectation that victims would appraise their CSA experience as negative. 'Harm/loss' and 'threat' appraisals were more frequently indicated than 'benefit' or 'challenge' appraisals. The most potent threat was the break up of the family. The 30% of girls who appraised the event as challenging or beneficial were less likely to report overall distress, or distress over parents not believing them.
Overall, they concluded that how incest victims continue to appraise their molestation and cope with the associated emotions and problems appear to be more important than the characteristics of the abuse in determining current adjustment.

1.5 *Attributions of self-blame: can they be useful?*

Self - blame is a common response by victims of rape (Burgess & Holmstrom 1974, Janoff - Bulman, 1979) and other victimisations, eg., battering (Frieze, 1983). As discussed below, the attributions victims make of responsibility do not always operate in the way traditionally assumed by many mental health professionals. Attributions are attempts to explain events, and self - blame attributions, according to Janoff -Bulman & Lang - Gunn (1983) seem to adequately explain why the event occurred to the victim in particular. For example, blaming oneself, or accepting responsibility in an uncontrollable situation may be the only means of maintaining a

sense of control, and therefore may be associated with less serious impact , i.e., if the individual is responsible, then she/he is in control (Janoff - Bulman & Frieze, 1983). Research has not directly focused on attributional beliefs of child victims of CSA and how these beliefs are associated with the effects of such experiences. If certain attributional statements are associated with more serious impact, then these attributions may become the target of intervention. Miller and Porter (1983) propose theories and review research about attributions of blame in victims of violence, and conclude that self-blame can have adaptive consequences - which is contrary to the dominant conception that self-blame both causes and maintains depression (Abramson, Seligman & Teasdale, 1978).

They propose that 3 psychological needs are served by self-blame:

1) Need for perceived control over ones life, i.e., the acceptance of responsibility enables individuals to maintain the belief that they are in control of their lives.

2) To ward off cognitive dissonance, i.e., most individuals believe the world is an orderly, fair, just place, and bad things do not happen by chance.

3) People have a need to impose meaning on significant events. Self blame can serve to give meaning to events that are otherwise incomprehensible (Silver and Wortman, 1980). Unfortunately the above ideas have not been adequately empirically explored, and although feasible, the researcher based her hypotheses of self-blame and outcome of CSA victims on the theory proposed by Peterson & Seligman (1983) and Hegelson (1992).

Peterson & Seligman (1983) propose, based on Seligman's (1975) theory, that reactions to uncontrollable aversive events have been termed "learned helplessness", and victims learn during the victimisation process that responding is futile. Uncontrollability over the onset and termination of the victimizing events is one of the defining characteristics of a victimisation episode - and one of the most common responses to a victimisation episode that is seen as uncontrollable is emotional numbing and passivity (see further section on "avoidance coping"). Not all people exposed to victimisation show numbing and passivity, or develop maladaptive coping responses.

Abramson et al (1978) stated that people vulnerable to such reactions interpret these 'bad' events in internal, stable and global terms - thus the need for an understanding of individual differences of appraisals towards CSA. Hegelson (1992) takes this proposition further.

According to Hegelson (1992) the more severe the threat, the greater a person's need to establish control. It follows from Janoff -Bulman's (1983) argument then, that children experiencing CSA, which is assumed to be an overtly 'uncontrollable' stressor, will try to establish control and make sense of the event by blaming themselves. However Hegelson's (1992) research indicates that the beneficial effects of personal control beliefs increase with threat severity only when the threat is controllable, but decrease with threat severity when the threat is uncontrollable. Her research concludes that *perceptions of control must be based in reality, for beneficial effects to occur.* Precisely because child sexual abuse is *not* the responsibility of the child, but occurs at the initiation of the perpetrator and is the sole responsibility of the perpetrator, the present research predicts that self blame appraisals made by sexually abused children will not be useful and will be associated with higher depression scores. Given that self - blame is a common response to victimisation, it is expected that most sexually abused children in the current study will make this appraisal, which is expected to be maladaptive.

Overall, while positive cognitive distortions (including illusions of control) are often adaptive (Taylor and Brown, 1988), some researchers have stated that it is not beneficial to perceive control in an uncontrollable situation (Cohen & Lazarus, 1983), and Folkman (1984) claimed that the risk of maladaptive outcomes increases when the appraisal of control is not consistent with reality. This is consistent with Taylor et al., (1991) who suggested that illusions of control need to operate within realistic boundaries to be adaptive. The extent to which perceived control leads to increased or decresed adjustment is not yet fully known.

2. *"COPING" AND COPING STRATEGIES*

2.1 *The Concept of coping*

Some researchers choose not to define "coping", as definitions and meanings of coping prove complicated and are varied. Rutter (1981) in his address to the Association for Child Psychology and Psychiatry in the United Kingdom, stated that the whole area of coping is diffuse and unsatisfactory (Frydenberg and Lewis, 1991). Instances of difficulties with coping concepts and theory arise, for example, in discussing whether defense mechanisms are coping strategies, or whether an individual's automatic efforts are included as coping efforts. Problems arise when it comes to distinguishing defense mechanisms as rigid patterns of behaviour that ultimately become maladaptive coping behaviours, whereas coping behaviours are seen as flexible, purposeful and adaptive responses to stressors (Folkman & Lazarus, 1984).

Billings and Moos (1981) addressed the operationalisation of the concept of coping by proposing several methods of coping available to individuals. According to them, coping responses can be clustered into 3 categories: active-cognitive, active-behavioural or avoidance. Researchers also discuss emotion vs problem focused coping, where emotion-focused coping aims to deal the with the emotions causing distress as a result of the stressor, and problem-focused coping deals with changing the stressor or situation (Lazarus et el 1984); behavioural vs cognitive, active vs passive and conscious vs unconscious are all examples of coping distinctions. It is thus apparent that a number of approaches have been taken to classify coping behaviour, however they all have 2 distinctions in common, i.e., the difference between "confrontational" or "active" strategies and "avoidant" strategies. The former involve behaviours that seek to change the stressful situation or control the distress, the latter involve behaviours that (a) avoid dealing with the problem, or indirectly reduce the

tension associated with the problem (eg smoking, eating) and (b) control the distress associated with the problem.

The current study is congruent with Folkman &Lazarus' (1984) definition of coping as a *process*, rather than trait. Assessment is concerned with what the child actually does or thinks, within a specific context. It is necessary to do this to evaluate coping within a context properly. The coping process is continuously mediated by cognitive reappraisals which differ from appraisals primarily in that they follow and modify an earlier appraisal.

Folkman and Lazarus have defined a number of coping sub-scales over the years, however the present study uses the following subscales (Folkman, Lazarus, Dunkel-Schetter, De Longis & Gruen 1986):

1. Confrontive coping
2. Distancing/Detachment
3. Self-Controlling
4. Seeking Social Support
5. Accepting Responsibility/Self Blame
6. Escape-Avoidance/Wishful thinking
7. Planful Problem-Solving
8. Positive Reappraisal

2.2 ***Definition of Coping***

The present research adopts the definition of coping originally offered by Lazarus and Launier (1978) namely: *"efforts both action-oriented and intra-psychic, to manage (ie., master, tolerate, reduce, minimise) environmental and internal demands, and conflicts among them. which tax or exceed a person's resources"* (p. 311). Similarly, a primary definition of coping utilised in the literature and relevant to the present study, was presented by Lazarus and Folkman (1984): *Coping is "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the the resources of the person"*

(p. 141). Primarily, coping refers to overt and covert strategies that an individual uses to reduce the impact of a stressful event on functioning. Measurement of appraisal and coping in the present study is based on the above definitions. Folkman and colleagues (1984) stress that coping is not a trait, rather a process which involves change, as the encounter unfolds. Secondly, they view coping as contextual, ie., influenced by the person's appraisal of the actual demands in the encounter and resources for managing them. Person and situation shape coping efforts. Third, they argue that good or bad coping is not the issue, rather, what is importnt are the persons' *efforts* to manage the situation/demands, whether or not the efforts are successful. "In order to determine the effectiveness of coping and defense processes, one must be open-minded to the possibility that both can work well or badly in particular persons, contexts or occasions" (Folkman & Lazarus, 1984, p. 133)

Kahn et al (1964) pointed out that the study of coping behaviour should include failures as well as successes. For example, not all sources of stress are amenable to mastery or even fit a problem - solving framework, eg, death of a loved one, losses, natural disasters, rape, disease and perhaps CSA. As Folkman & Lazarus (1984) explain, "emphasising problem solving and mastery devalues other functions of coping that are concerned with managing emotions and maintaining self esteem and a positive outlook, especially in the face of irremediable situations. Coping processes that are used to tolerate, minimise, accept, ignore, are just as important in the person's adaptational repertoire as strategies that aim to master the environment" (p.139).

A definition which was not used for the present study was that discussed by Eiser (1991). If stress is understood interms of a series of problematic situations or stressors, it follows that adjustment should be determined in part by individual competence in dealing with the situations. "Competence is defined in terms of the effectiveness of the coping reponses emitted when an indidual is confronted with problematic situations" (Varni & Wallander, 1988, p. 215). Eiser (1991) states that effective, active coping responses result in a change so that the situation is no longer problematic, while at the same time producing a maximum of additional positive

consequences. This is difficult to assimilate into CSA research, as children who are sexually abused often do utilise coping strategies, however the physical situation of regular abuse continues, and despite what she does to change the situation (unless disclosure occurs) the stressor remains . How she/he deals with this fact is what is important in recovery (as many children do not disclose for years). What may change, and is important for thearapeutic work, is how the child attributes meaning to what is happening to her, how she regulates emotions as a result of this, and how she assimilates the experience and its emotional effect into her life.

2.3 ***"Avoidance" vs "Confrontive" Coping Strategies***

Avoidance coping strategies, or "denial", "distancing", "escape-avoidance" may be useful or detrimental, depending on the context, person and situation. Braun (1984b) has proposed a continuum of dissociative phenomena that includes, in progressively more serious order, normal behaviour, dissociative disorder, post-traumatic stress disorder, and multiple personality disorder. The section following refers to "distancing" as a behaviour that could either remain as 'normal' behaviour, or become a symptom of dissociation.

Most studies indicate that "avoidance" may occasionally be helpful in the short-term, however maladaptive in the long term. (Folkman &Lazarus,1984, Armistead et al, 1990). Use of active attempts have been found to be associated with less stress relative to the use of avoidance-type responses. For example, Billings and Moos (1981) found that the avoidance method of coping detrimentally influences functioning in adults. Their findings are supported by Holahan and Moos (1987), who found the use of avoidance coping strategies to be a risk factor for psychological distress in adults, and Armistead et al (1990), who found that avoidance coping was associated with poorer functioning for adolescent girls (their sample had a small representation of males). Similarly, Johnson & Kenkel (1991) found that wishful thinking (the coping strategy where children "fantasise, daydream and wish" things

could be better than they are in reality) emerged as the most significant coping predictor of global distress in incest victims.

Leitenberg et al (1992) conducted a retrospective study of long term coping methods with having a sexually abusive childhood. Their hypothesis was that since the psychological effects of many other stressful and traumatic life events have been shown to be influenced by different coping methods, (Garmezy and Rutter,1983) it seems reasonable to expect that this would be the case as well for childhood sexual abuse. They found that "denial" and "emotional suppression" were the coping methods most commonly employed by women recalling experiencing CSA. Although women reported these strategies as being helpful at the time, the research demonstrated that these coping strategies were associated with poorer adult psychological outcome. Ebata and Moos (1991) conducted a study focusing on avoidance and confrontive coping strategies in clinical population adolescents. They found that depressed adolescents and adolescents with conduct disorder use more avoidance coping than rheumatic disease and healthy adolescents. Their results suggest that efforts to change, manage or positively reappraise a problematic situation actively, are important for good long term adjustment. Ebata and Moos (1991) conclude that adolescents who engage in more avoidance coping may be at greater risk for poorer adjustment to subsequent life stressors and crises.

What does emerge from the literature however is an interesting interplay between theory on severe threat appraisals where the situation is seen as unchangeable, and "avoidance" coping as a useful coping strategy in these situations. Folkman and Lazarus (1980) found that problem-focused forms of coping were used more often in encounters that were appraised as changeable, and emotion -focused forms of coping (distancing, escape-avoidance) in encounters that were appraised as unchangeable. This finding was confirmed by Folkman, Lazarus, Dunkel - Schetter, DeLongis and Gruen (1986), which showed that when Ss appraised encounters as having to be accepted, they turned to distancing and escape-avoidance. As Collins et al (1983) indicate, distancing may be an adaptive response to a situation that is seen as negative

and unalterable. Denial or avoidance in the context of illness however is considered ineffective because the person fails to engage in appropriate problem solving coping (eg seeking and maintaining medical attention). According to Folkman &Lazarus (1984) , denial closes the mind to whatever could be threatening. However they do offer some ideas as to when denial and avoidance may have favourable outcomes:

1. When there is nothing that can be done to alter the threat or harm, without the potential of producing additional harm (as often perceived in CSA).
2. Denial may be helpful for parts of a situation, not the whole: eg, it may be more harmful to deny that one has cancer than to deny that the illness may be terminal (in thelatter case, strategies such as positive thinking and hopefulness can be beneficial)
3. In chronically uncontrollable and/or unchangeable situations (Miller, 1980).
4. In the early stages of a crisis, eg death of a loved one, sudden illness (Hackett et al, 1975, Cohen and Lazarus, 1983).

Similarly, Wortman and Dintzer (1978) write: "We believe that many of the behaviours associated with helplessness (giving up, losing interest in the outcome, and/or motivation to pursue it) are maladaptive only when the outcome in question is controllable or modifiable. If the outcome is truly uncontrollable, these behaviours may be highly functional" (cf. Weiss, 1971, p.87).

Reviewing Garber and Seligman's (1980) book, Synder (1982) states that "...we still lack an adequate understanding of the consequences of experience with uncontrollable outcomes" (p.11) As Folkman & Lazarus (1984) state "Indeed, we do not yet know how to predict how a person will cope with the conditions that bring these outcomes about, nor with the outcome themselves, in both the short and long run. These are crucial research questions for the future if we are to come to terms with the problem of control or lack of control over the environment and its relationship to outcomes such as morale" (p. 205).

To summarise, context, situation and person must be taken into account when examining the usefulness of denial as a coping strategy, however what seems to be significant is the potentially useful association between uncontrollable events and the

use of "denial" to cope with these events until the termination of the stressful experience.

2.4 *Studies on Childhood Coping*

Most research on coping has been conducted with an adult population - how children and adolescents deal with stressors, until very recently, has been a neglected area of research. It is clear children experience a wide range of stressors, including parental or sibling death, divorce, chronic illness, peer pressure, family violence, abuse and so on. Coping ability however is a variable that is perhaps more important to children's functioning than is the nature of the stress itself, as research shows divergant psychological outcomes under same - stress conditions (Rutter, 1983) eg., resilience, different coping sources and styles. As with adult coping, most researchers define coping in child studies as the one defined in present study, ie., effortful responses. However more importantly than with adult coping, it is essential to take into account the child's social context when looking at her coping behaviour - the nature of the young child's dependence on adults for survival emphasizes the need to include the child's social context in understanding her coping resources, styles and efforts (Leiderman, 1983). "In contast to the relatively autonomous adult, the young child utilises other people as part of the coping mechanism; thus the child must use the social system as part of the effort at adaptation an survival" (Rutter , 1984, p. 138). This makes children's coping with sexual abuse even more significant, as often those whom the child depends upon most are violating that position of trust, protection and support, thus the child's own coping strategies become of primary importance.

Besides social context, the child's temperament is is often cited as playing a central role in influencing the child's coping responses (eg., Kagan, 1983; Rutter, 1981). Children differ in their psychological and biological "preparedness" to respond to stress - some are more fearful or anxious, others rarely perceive threat in their environment. Studies on resilience in children examine factors that may moderate

the relationship between stressors and adjustment, and characteise "resilient" children and adolscents, who fare well despite developmentally threatening conditions (Garmezy, 1983, Rutter, 1987; Werner & Smith, 1982).

Cognitive and social development are also likely to affect what children experience as stressful and how they cope (eg., Maccoby, 1983). Important aspects of development include self-perceptions (Harter, 1983) self-efficacy beliefs (Bandura, 1981), self-control or inhibitory mechanisms (Harter, 1983), attributions of cause (Ruble & Rholes, 1981), friendships (Hartup,1983), and parental relationships (Maccoby & Martin, 1983). As Compas (1987) says - although it is beyond the scope of this paper to review each of these areas - it is important to recognise the ways in which the study of coping during childhood and adolescence can contribute to as well as benefit from developmental research. Band and Weisz, (1988) reported that children as young as 6 years old are sufficiently aware of stress and coping in their own lives to report on conditions and events they find stressful, describe their own efforts to cope, and evaluate the efficacy of those efforts. Brown et al (1986) found that children who catastrophise and focus on negative aspects and unlikely consequences have higher anxiety scores. 'Copers' used positive self talk -"I can take this", task orientation, problem-solving, deep breathing and diverting attention, from pain related to dentist visits. Branson and Craig (1988) interviewed children about their coping strategies when dealing with physical pain, and together with Ross and Ross (1984), came up with:

- distraction methods (eg., counting holes in ceiling)
- physical procedures (eg., clenching fists)
- thought stopping, relaxation, imagery, fantasy

Curry and Russ (1985) identified 6 cognitive coping subtypes

- reality oriented working through (eg., this is where he gives me a filling)
- positive cognitive restructuring (e.g., I tried to think good thoughts)
- defensive reappraisal (eg., I thought the shot wasn't to go into my skin)
- emotion-regulating cognitions (eg., dont worry, it's going to be OK)

- behaviour regulating cognitions (eg., "be still")
- diversionary thinking.

Branson and Craig (1988) reviewed studies which report differences in coping between younger and older children. Five to 8/9 year old children tended to use behavioural "direct action" to cope with pain, whereas children 11-13 reported a number of psychological abd cognitive strategies. Some studies report 8-10 year olds supplementing behavioural strategies with cognitive.

2. "ABUSE CHARACTERISTICS" INFLUENCING IMPACT OF CHILD SEXUAL ABUSE

To date, research findings of identified factors associated with the differential effects of CSA are inconsistent. The key factors researched are: sex and age of child, frequency and duration of CSA, type of CSA, type and frequency of coercion used, degree and quality of relationship between perpetrator and child, who the perpetrator is, disclosure variables, whether the primary parent believes the child, and family functioning. Overall, there is consistency that long term harm is associated with sexual abuse involving a father or stepfather, and abuse involving penetration (Russell, 1984). Longer duration of CSA is associated with greater impact, as is the use of force or threat of force (Beitchman et al, 1992). Age of onset has been included in studies extensively, however it's effects remain inconclusive as seen by results from Browne and Finkelhor (1986), Courtois (1979), Bagley and Ramsey (1986), Murphy et al (1988).

Conte (1984) found that victims were more seriously affected by the following: more intrusive sexual behaviour, negative relationship between victim and siblings, and more problems in living (eg, unemployment, family disruption). Conte and Schuerman's (1987) findings showed overall variance in symptoms to be attributed to:

Number of types of CSA, supportive relationships with significant others, victims receipt for some kind of reward for the sexual abuse, vicims effort to escape, resist or avoid the abuse, physical restraint of the victim during the abuse, passive submission by the victim to the abuse, fear of negative consequences to self if abuse revealed, offender's denial that abuse took place, victim's perception of her/his relationship of offender as otherwise positive and degree of relationship between offender and victim. Shapiro (1991) found the following factors to be associated with differential impact of CSA: the perpetrator being the child's father or paternal figure, the primary parent not believing her/his child during or after disclosure, the primary parent making the child recant her/his allegations, threats of violence and derogatory remarks during the sexual abuse, the primary parent saying they believe the child however the interpersonal relationship suffers because of inconsistent and confused behaviour from the parent. Seidner & Calhoun (1984) found that risk factors varied even with a single sample, depending on the measure employed to describe the effects of CSA. On the whole they found the following factors were associated with more severe effects: use of force, frequency, duration, gteater age difference between offender and victim, and attributional statements about responsibility.

The literature on CSA also shows how 'secondary abuse' can be more distressing and traumatic than the abuse itself, ie., parental disbelief, family disruption (especially in instances where the child is made to leave home) welfare, legal and medical procedures, the offender not prosecuted resulting in no sense of justice witnessed by the child, the child thinking her/his experience was not stressful at the time, and later being told how awful it should feel to have been sexually abused (Powell, 1991).

3. EFFECTS AND CONSEQUENCES OF CHILD SEXUAL ABUSE

3.1 *Psychological effects*

Over the last 20 years, research and professional interest and concern in the area of child abuse, has spurred a fast growing plethora of literature on the effects of CSA on children. The literature indicates that most children are profoundly traumatized by CSA, some exhibit milder or transient problems, and a small percentage appear not to have been immediately affected by the abuse (Constantine, 1980; Adams -Tucker, 1982; Fromuth, 1986; Henderson, 1983; Browne and Finkelhor, 1986; Briere & Runtz, 1986; Mrazek & Mrazek, 1981; Murphy et al., 1988; Hotte & Rafman, 1992; Chu & Dill, 1990; Kinzl & Biebl, 1992).

It is also necessary to differentiate between short and long term effects - as Gelinas (1983) states "since the effects of incest are not always obvious at the termination of sexual contact, and interviewing children at disclosure will not reveal whether delayed negative effects will occur, the negative consequences of incest have a..."time bomb" quality, especially because the victim cannot avoid situations which may function as developmental triggers..." (p. 318). Also, there may be "sleeper" effects, the results of which may emerge in adulthood. As Rosenfeld et al (1979) noted, the repercussions of incest may be "subtle and varied", and multidetermined, and may manifest themselves "immediately after the event or considerably later in life" (p. 327). Where there are immediate effects, Friedrich et al (1987) state that long term consequences will be similar to initial cosequences, particularly depression and problems with intimacy.

The bulk of research studies on the effects of CSA demonstrate the damaging psychological effects CSA has on it's victims (Hotte & Rafman, 1992). Empirical research has documented the profound and negative effects of sexual abuse of children - symptoms may include: depression, anxiety, fear, guilt, feelings of powerlessness, "damaged goods syndrome", repressed or expressed anger and

hostility, nightmares, failure to accomplish developmental tasks, impaired ability to trust, suicidal ideation, dissociative disorders, multiple personality disorder, blurred role boundaries, low self-esteem., inappropriate sexual behaviour, substance abuse and a tendency towards revictimization later on in life (Browne & Finkelhor, 1986; Gold,1986; Adams -Tucker, 1982; Murphy et al 1988; Beitchman et al 1992). Oates et al (1985) conducted a study with Australian subjects, assessing self-esteem of abused children. They found that sexually abused children had lower self esteem, perception of fewer friends and were less ambitious than matched controls.

Dr. Roland Summit (1983) refers to the "sexual abuse accomodation syndrome" as typifying the most usual reactions of children who have been sexually abused. The syndrome is composed of 5 categories:

1) secrecy: CSA happens only when the perpetrator is alone with the child, and the child is nearly always told that it must not be shared with anyone else. She/he is invariably threatened either with the break-up of the family, physical harm to the child, or told that the perpetrator will not love them anymore, and/or nobody will believe her/him if she/he told. However gentle or menacing the perpetrator is, the secrecy makes it clear to the child that the experience is something bad and dangerous.
2) helplessness: The prevailing reality for the most frequent victim of CSA is that it is not a one off incident that occurs in a public place, but a relentlesssly progression intrusion of sexual acts by an overpowering adult in a one-sided victim-perpetrator relationship. The fact that the perpetrator is often is often in a trusted and apparently caring position only increases the imbalance of power and underscores the helplessness of the child.
3) entrapment and accomodation: If the child did not receive immediate protective intervention (to disclose after the first incident is unusual, particularly with intra-familial CSA) the child learns to accept or deal with the situation. Summit proposes that it is during this phase, which can last for years, that the child learns to cope in whatever

way necessary for survival - to accomodate to the continuuing reality of sexual demands, as well as the continuing betrayal of a "caring" entrusted adult.

4) delayed, unconvincing disclosure: Most children within ongoing abusive relationships never disclose (Herman, 1981) or do so after years of sbuse. Summit (1983) states that children fear that they will be disbelieved and blamed, as well as having realistic fears of family break-up.

5) retraction: Most children recant their disclosure, either from pressure of the offender and/or nonoffending caregiver, because of their own bewilderment, shame and guilt, and/or because of their need or desire to preserve the family unit. Researchers have documented the traumatic effects of unsupported disclosure (eg Sgroi,1982, Conte & Schuerman, 1987).

According to Summit's formulation, the above factors contribute to the psychological and behavioural consequences of CSA.

Among models used to explain the trauma of sexual abuse, the one most frequently mentioned is the Post Traumatic Stress Disorder model, the symptoms of which are similar to victims of PTSD - eg., flashbacks, memories and triggers, nightmares and dissociation (Curtois, 1986; Frederick, 1986; Finkelhor, 1987). Consistent with this model, Finkelhor (1987) explains the process of this model as applied to victims of intrafamilial CSA as involving elements of betrayal, stigmatisation and powerlessness. Betrayal (as displayed by the 'relationship with perpatrator before and after abuse' variable) involves not only the betrayal by a person who is supposed to have a caring, protective and nurturing role, but also by significant others not believing, validating or supporting the child post-disclosure (Herman, 1981). Stigmatisation refers to negative messages about the self - unworthiness, shamefulness, guilt - messages which are communicated by the perpetrator and society in numerous ways: through secrecy, denigration, other's moral judgements and implication by some parents that the child must somehow have seduced the offender. Powerlessness involves firstly, the child's wishes and self-efficacy repeatedly being overwhelmed,

denied and frustrated, and the child experiencing threat of injury or other harm. As Finkelhor (1987) states, perhaps the most basic form of powerlessness is the experience of having one's body repeatedly invaded against one's wishes, as well as possible life or family threat. These factors are important in the appraisal and coping process of the child. Briere and Runtz (1986) confirm the role of self blame, stigmatisation and powerlessness increating and maintaining depression in CSA victims.

3.2 ***Family Pathology or sexual abuse?***

It is clear that various symptoms have been reported to occur in the aftermath of CSA, however due to methodological limitations of most CSA research, ambiguity exists as to which effects may be directly attributed to the abuse and which may be related to other antecedant ot concomittant variables, such as family pathology, post-disclosure reactions, severity of abuse, whether force was used etc. Studies in the mid-80's (eg., Conte & Schuerman, 1986) showed that factors which determine effects of CSA are directly related to the variables surrounding sexual abuse (eg., type of CSA, frequency, duration, quality of relationship between offender and perpetrator, type of coercion used). This framework for working clinically with effects of CSA on children has some limitations, as the understanding of potential trauma to the child can be misunderstood and thus poor, for example, studies indicate that trauma from CSA may be sustained in the 'mildest', non-forceful and infrequent incidences. Basta & Peterson (1990), conclude from their study on perpetrator status and effects on children, that a relatively noncoercive style of abuse can still produce significant psychological impairment. They also show that trauma which results from sexual victimisation could be due to sexual abuse per se, regardless of the relationship of the offender. Ie., the question is not whether one type of abuse is more serious than the other (eg masturbation vs intercourse, stranger vs family member) but rather *what specific injurious dynamics were present,* ie., what was the worst part for the child,

and how she dealt with it. As Nash et al (1993) state "A satisfying, empirically based understanding of how childhood sexual abuse affects later adult adjustment remains quite elusive despite extensive study"(p. 276).

More recent studies (e.g., Johnson & Kenkel, 1991. Nash, 1993) show that variables which influence the impact of CSA on children are more likelyto be

1) cognitive processes that children use to appraise and cope with the abuse, and
2) stability/dysfunction of the family, ie the context, in which the abuse occurred and was maintained., as well as the connected variable of degree and type of support from nonoffending parents.

Recent studies once again are pointing to negative effects of CSA being influenced by family dysfunction (a line of thought also prominent in the 1970's). A common methodological limitation in this type of research is separating the sexual abuse from the role of family functioning in causing later problems. Nash et al (1993) in a retrospective study comparing 105 sexually abused and nonabused women found that CSA was associated with greater use of dissociation, but statistically this was accounted for by family pathology, rather than abuse per se. They found that family environment appeared to be an important mediating variable in determining the general level of adult psychological distress. They conclude that CSA has a negative effect, combined with the family context in which it was embedded. (NB: this was a retrospective study - women may overestimate the degree of disruption in their family *precisely because they were abused).* Prior to Nash et al's (1993) study, a considerable body of research indicated that victims of sexual abuse come from families that are disturbed, or are perceived by victims as dysfunctional, or that engage in maladaptive patterns of interaction (Herman, 1981; Jackson, Calhouen, Amick, Maddever & Habif 1990; Madonna, Van Scoyk & Jones, 1991). A more recent study by Yama et al (1993) found that family conflict was linked with the effects of CSA on depression and anxiety in women. The direct effect of family environment itself was inconclusive, however their results indicated that family conflict and a less cohesive family, *coupled* with CSA produces an internalised traumatic situation that predisposes

children to later adult psychopathology. It is to be noted that they did find a direct link between CSA and depression and anxiety, which cofirms previous research findings (eg Browne and Finkelhor, 1986).

A relevant study which clearly delineaties the role of dysfunctional families and CSA on girls was conducted by Hotte & Rafman (1992). Unlike studies by Nash et al (1993) and Yama et al (1993), their study included a comparison group of non-sexually abused girls living in dysfunctional families, as well as the experimental group of girls experiencing incest living in dysfunctional families. Their rigorous research demonstrated that the impact of incest on young girls (8 - 14 years) cannot simply be ascribed to the child coming from a multiproblem family. The girls who had undergone incest had significantly lower self-esteem, turned aggression against themselves more often, exhibited more inappropriate or confused sexual behaviours at an early age and had more problematic relationships with their mothers, than the group living in multiproblem families who had not undergone incest. Their conclusion that the inherent psychological and sexual exploitation and betrayal of the child by an adult whose expected function is to protect her/him, confirms Gelinas' (1983) clinical study: "Exposure of the child to chronic marital estrangement, inadequate parenting and role reversal with the mother is obviously not optimal and can lead to some negative effects later in life. But such exposure will not produce a traumatic neurosis. Sex with a parent usually will. It is clear that the traumatic neurosis and its related elements (such as flashbacks, repressed memories) are attributable to the incestuous sexual abuse" (p. 330).

In terms of direct effects of CSA on women, it is also clear that abused women in contrast to nonabused women score higher on dissociation, physical disturbance, somatic problems, anxiety, depression and sexual dysfunction (Bagley & Ramsey, 1986; Briere & Runtz, 1988; Chu & Dill, 1990, Murphy et al, 1988). Knowledge about the frequency of CSA among patients with mental and psychosomatic disorders is increasing, with numbers as high as 70% being found amongst clinical populations (Kinzl & Biebl, 1992). Scott (1992) in an American

epidemiologist analysis (n=3,131) found that a history of CSA significantly increases an individual's odds of developing eight psychiatric disorders in adulthood, including Affective disorder, OCD, Substance Abuse, and Depression. Based on her statistics, Scott (1992) estimates that on a community level, 74% of the exposed psychiatric cases, and 3.9% of all psychiatric cases within the population can be attributed to childhood sexual abuse. These results confirm numerous studies that demonstrate the psychological toll CSA takes on its victims (Bagley & Ramsey, 1986; Finkelhor, Hotaling, Lewis & Smith, 1989; Peters, 1988). In addition, studies by Bulik, Sullivan & Rorty, 1989; Bryer, Nelson, Miller & Krol, 1987 Greenwald, Leitenberg, Cado & Tarran, 1990 and Morrison, 1989, all demonstrated high rates of childhood sexual abuse experiences in patients with depression, substance abuse, eating disorders, sexual disorders, multiple personality disordes, posttraumatic stress disorders and borderline personality disorders. Orr & Downes (1985) report from their study, using a control group, that sexually abused youth had significantly more problems with psychopathology, educational goals and ability to master the environment.
The self-concept problems identified in their sample of sexually abused youth are similar to those reported by women seeking psychiatric care long after their CSA occurred, as well as sharing some features reported among physically abused adolescents (Hjorth & Ostrov, 1982).

Given the implications from these studies of profound and far-reaching effescts, it is extremely useful to increase knowledge of means of coping, recovery and adjustment in victims of CSA. Herman, Russell & Trocki (1986) write, clinical studies, while helpful, do not offer a full picture of the range of adaptation and recovery in in victimised children. " In the first place, only a small percentage of abused children are ever seen by by mental health or social agencies. We do not know whether the large majority of children whose abuse remains undetected fare better or worse than do the children who come to our attention" (p. 1293)

Einbender & Friedrich (1989) examined the relationship of abuse to several broad categories of childhood functioning, including cognitive abilities and school

achievement, emotional functioning, and overt behaviour problems. They also focused on the family context, and behavioural difficulties that may result from lowered quality of family relationships. By comparison with a matched group (age, sex, ses, race, family constellation), the CSA group demonstrated significant problems on the above criteria, however no significant differences regarding family functioning and effects were evident .

Famularo, Kinscherff & Fenton (1990) studied Post Traumatic Stress Disorder (PTSD) in their sample of 28 children. All had been physically and/or sexually abused. They found differences between the acute and chronic group. Children with the acute form of PTSD presented relatively more frequently with acting as though the trauma were recurring upon real or symbolic re-exposure, difficulty falling asleep, nightmares, hypervigilance, exaggerated startle response, and generalised anxiety and agitation. Children presenting with the more chronic form showed more symptoms of detachment, restricted range of affect, thoughts that life will be too hard, dissociative episodes, and sadness. The authors caution that their results represent only quantitative and not qualitative differences between the subgroups.

3.3 ***Comparison between male and female victims of child sexual abuse***

While the population of male victims has been assumed to be significantly lower than female victims, data show the ratio of female/male victims as 2:1 (De Jong, 1982). Pierce and Pierce (1985) found that force or threat of force were significantly more common among male victims of CSA than among females. Rogers and Terry (1984) reported that male sexual abuse victims showed confusion of sexual identity, inappropriate attempts to reassert their masculinity, and recapitulation of the abuse experience. Literature tends to show that sexually abused male children are more likely to externalise behaviour in the form of aggression, repeat sexual abuse upon yonger children, have conduct disorder and be more sexualised (Friedrich, Bielke and Urquila,

1987). Friedrich et al (1988) in a further study showed girls as displaying more internalising behaviour post abuse, and boys more externalising. Longo (1982) found in a sample of male adolescent sex offenders, that 47% had been sexually abused as children, and Becker (1988) reported a 19% incidence of CSA among male adolescent sex offenders (n = 139). While the evidence is suggestive and warrants further research, there is an insufficient number of controlled studies on effects of CSA on males from which to state findings unequivocally. Pierce (1985) reports that males are less likely to report their abuse, perhaps because it brings their masculinity into question (as most boys are abused by men, although data shows that women perpetrate sexual abuse against boys also), however perpetrators who offend against boys are more likely to go to jail (Pierce, 1985). Pierce (1985) also found that compared to female victims, males receive less treatment, as determined by therapists (16 hrs vs 39 hours on average).

4. ***Methodological Issues in Child Sexual Abuse Research***

The following points have been noted as significant areas that have often impeded research and constrained generalizability of findings in the field of Child Sexual Abuse research. The present study attempted to take into account the above mentioned methodological criticisms as much as possible, given the limited resources and level of the study.

1. *Sample size*: Due to the difficulty of recruiting an adequate sample size given the sensitive nature of the research topic, most sample sizes in CSA research are small (ranging sometimes from 1 to 3) and thus often having inadequate statistical power. (Hotte and Rafman, 1992, De Young, 1982, Schetky and Green, 1988). Other problems with samples are that when victims of CSA are studied, they are generally

women, which while being valid and informative, are complicated by their nature of being retrospective studies (Brooks, 1982).

2. *Control Groups:* A common problem in CSA research is a lack of adequate (or any) comparison or other control groups and procedures, eg., matched samples, nonclinical controls. (Haugaard & Repucci, 1988 and Basta & Peterson, 1991). A point underscoring the importance of information from children themselves and a comparison group is made by Powell (1991): "the presence of psychological or behavioural problems should never be regarded as evidences that abuse has occurred in a particular case" (p.78).

3. *Use of standardised objective measures:* until recently, the scales and measures used to index the effects of abuse have been unstandardised and non-normed measures of adjustment (Garrett, 1979; Goodwin, 1982)

4. *Confounding of abuse with other pathogenic factors:* Some adult pathology associated with CSA may covary with or reflect the effects of a broadly pathogenic home environment rather than those of CSA per se, thus it is important to match for home environment for nonspecific effects of incest - to differentiate between effects of neglect, physical abuse and other forms of maltreatment occurring in the family home (Hotte & Rafman 1992) which can prove extremely difficult statistically (Briere, 1988). Causality re efefects of CSA is almost impossible, due to the possibility of multiple influencing factors : "Chaotic or conflict-laden families may produce various types of child abuse and neglect, along with other more subtle traumas (eg., "object loss" arising from paternal abandonment, confusion due to inconsistent parent roles), unknown combinations of which may produce long-term effects. Thus, from this viewpoint, a history of sexual abuse may covary with symptomatology because such experiences reflect (or are an example of) broader family dysfunction" (Briere, 1988, p.81). In the present study the researcher attempted to gage this by examining the

"appraisal" variable, eg.," I thought this (ie.CSA) was a normal part of growing up", "I thought this happened to all kids".

5. Failure to match for the child's age or level of development.

6. *Variables associated with "secondary abuse":* It is important to include confounding variables in the design which may otherwise bias results, particularly in cases of CSA, eg., multiple interviews and interrogations, disbelief by family members, social reactions, legal outcomes, and other stressful experiences arising from the discovery of the abuse (Finkelhor, 1979; Yates, 1982).

7. Lack of discrimination between acute and long-term psychological sequelae (Green and Schetky, 1988)

8. Lack of control or provision of baseline for psychological impairment preceding any known sexual abuse.

5. *AIMS AND HYPOTHESES*

The aim of the study was to investigate the factors that lead to initial better or worse adjustment among children who have been sexually abused, based on Folkman and Lazarus' (1984) model of stress, coping and adjustment. In doing so the researcher examined how children appraised and coped with child sexual abuse, and investigated whether these cognitive processes were associated with psychological outcome. A further goal was to explore differences in high threat appraisals and subsequent coping strategies of abused and non abused children.

Hypotheses

(1) Based on the literature of effects of CSA, it is predicted that sexually abused children will have significantly higher stress appraisals than non-abused children.

(2) Following on from this, the researcher predicts that children in the abuse group will cope by using "avoidance" strategies most (Distancing, Escape-Avoidance), to reduce the emotional consequences associated with CSA. Studies have found that adolescents who have been sexually abused tend to use avoidance coping strategies more than other strategies (Ebata and Moos, 1991). It is expected that sexually abused children will use "avoidance" strategies more than non-sexually abused children.

(3) However, contrary to most research, it is predicted that avoidance coping strategies will be seen as *initailly* helpful with the sexually abused group and will be associated with lower depression scores, based on implications for future research by Leitenberg et al (1992) and Armistead et al (1990), as well as Folkman & Lazarus' (1984) and Wortman & Dintzer's (1978) proposal that "avoidance" coping strategies can be beneficial in high threat, "uncontrollable or unchangeable" situations.

(4) In order to examine the association between appraisals of which the meaning is central to the wellbeing of the person, and outcome, it is predicted that "self-blame", "stigma" and "loss" or "threat of loss", will be related to higher depression scores (Hammen & Goodwin-Brown, 1990, Finkelhor, 1984). It is predicted that the abuse group will use these appraisals significantly more than the control group, based on literature on victimisation (eg., Janoff-Bulman, 1983; Miller and Porter, 1983).

(5) The researcher will compare appraisal and coping strategies of sexually abused children with children who have not experienced sexual abuse in order to explore the relationship between perceived level of threat (stress appraisal) and subsequent coping strategies, irrespective of nature of stressor. Of particular interest will be the types of coping strategies all subjects utilise to deal with high-level stress.

(6) Investigate possible factors, external to coping strategies, which may mediate initial effects of CSA in children, such as type and frequency of sexual abuse, quality of perpetrator-child relationship.

METHOD

The research method was modified from it's original semi - structured interview design in order to gain a higher rate of agency cooperation. In the final format, 2 questionnaires were eliminated due to feedback from agencies regarding time constraints of staff, and non-completion of questionnaires. Despite changes being implemented, the sample size is nevertheless low, as many agencies who expressed interest for months, and stated that they would participate, then turned the research down in the last minute. This point relates to "methodological issues in CSA research" as discussed in the Introduction. The method discussed describes reviewed implementations which became the study.

Subjects

A total of 52 subjects between the ages of 7.5 and 15 years participated in the study (M = 11.6, SD = 2.3) . The primary group, the 'Abuse group' (Group 1) consisted of 26 children (20 female, 6 male) who had been sexually abused up to 18 months prior to the interview. This group was matched for age, gender, and as close as possible with family constellation by a control group (Group 2) consisting of 26 subjects. The initial requirement was for female subjects only, to meet homogeneity criteria, however due to the initial low response rate, males were included. Forty six percent (n =12) of the 'abuse group' Ss lived in 2 parent families, 54% (n= 14) lived in 1 parent families. Fifty four percent (n = 14) of the control group Ss were involved in 2 parent families, 46% (n =12) were involved in 1 parent families. Fifty four percent (n = 14) of parents of Ss in the abuse group were employed in P/T or F/T jobs, compared with 76 % (n = 20) of parents of Ss in the control group.

The children in the sexual abuse group met the following ctiteria: (a) The sexual abuse incident involved physical sexual contact, between perpatrator and child, (b) the perpetrator was at least 5 years older than the child (c) The child will have disclosed

sexual abuse to a health professional, Police, or Child Protection Worker. (Einbender and Friedrich, 1989). Sexual contact included one or all of the following: Kissing (open moth or kissing of body parts), touching of breasts and/or genitals, reciprocal masturbation, digital penetration, and oral, vaginal, or anal intercourse. The Ss in the control group met the criteria of experiencing a stressor in the last 18 months, as confirmed by a parent, and being within the age range and frequency of the abuse group. Stressors listed by the matched control group included:

Arguing between parents (23%) , overnight hospital stay minor surgery, bullying from school peers, argument with best friend, access visits where father and partner fight, teasing at school, exam pressure, school performance, break up of friend's family, (7%) close extended relative going OS indefinitely, indiscretion toward close friend, parents' divorce and living with dad, father developing new relationship after divorce, mother and father divorcing, mild behaviour problems of sibling, spiders, conflict with boss of a new casual job, death of a pet dog, grandmother's death. Parental separation, fighting, and issues surrounding post - divorce living constituted half of the stressors experienced by the control group.

Measures

Measures assessed how the child appraised and perceived the abusive or stressful experience, their coping strategies and psychological status, specifically measuring presence or absence of depression.

A clinical package containing the measures were distributed to all agencies and participants.

1. Children's Depression Inventory (CDI) (Kovacs, 1981).

The CDI was used in the current study as a measure of the child's adjustment, as depression and low self esteem are widely reported effects of CSA (eg., Murphy et al, 1988, Beitchman et al, 1992). The CDI is the most widely used self-report measure of

children's depression (Kazdin, 1981). It consists of 27 items, each allowing the child to select among alternatives on a 3-point scale reflecting degree of depressive symptoms including sleep and appetite disturbance, sadness, suicidal ideation, anhedonia. Each of the 27 items is scored from 0 to 2 in the direction of increasing psychopathology, to give a maximum score possible score of 54.

The CDI was developed through modifying the adult Beck Depression Scale. Kovacs and Beck (1977) found similarities between depression in adults and depression in children, grouping depression into 4 basic areas: 1) Affective changes 2) Cognitive changes 3) Motivational changes 4) Vegetative and psychomotor disturbance. The definition of depression used by Kovacs and Beck (1977) is in accordance with DSM 111 criteria for Major Depressive Disorder. Adequate reliability and validity data have been reported by Kazdin (1981). American studies have also confirmed the construct validity of the CDI (Carlson & Cantwell, 1980; Helsel & Matson, 1984). Kovacs (1981) reports that the co-efficient alpha of .86 supports the claim of reasonable internal validity, and the item total score correlation obtained were all statistically significant (.31 to .54). The CDI correlates with the Piers Harris Self Concept Scale as well as the Children's Depression Scale (Lang &Tisher, 1978) which indicates that they measure the same construct.
Carlson and Cantwell (1980) indicate that a score of 24 must be exceeded for severe depression, and a score greater than 18 in order to fall in the range of moderate depression. All children participating in the study completed the CDI.

2. Ways of Coping and Appraisal Checklist (WOC&AC) (Modified for children, from Folkman and Lazarus' Ways of Coping Checklist, 1984).

The definition used was of coping as a response to stress: Cognitive and/or behavioural efforts to manage specific external and/or internal demands that the child perceives as aversive and taxing (Folkman and Lazarus 1984 - modified)

In assessing cognitive - behavioural coping strategies, researchers frequently employ self-report rating scales, the most frequently used being Lazarus and Folkman's Ways of Coping Checklist, which attends to both emotion-regulating and problem-solving functions. Appraisal and coping strategies were assessed by this measure in this study. The original Ways of Coping Scale consists of 67 items describing both cognitive and behavioural strategies that can be used to cope with stressful situations. The current WOC&AC consisted of 63 items which were answered on a 4-point Likert scale as: not used (score of 0), used only sometimes (1), used quite a bit or often (2), or used almost all the time (3). Factor analysis of WOC items has yielded 8 coping sub-scales (Folkman et al, 1986) descibed below. Scores on coping strategies were obtained by adding up the Likert points per item and grouping them together into 8 sub-scales. The 8 sub-scales used were those developed by Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen (1986) (See Appendix for modified children's questionnaire).

For standardisation, the researcher kept in line with the 1986 subscales and their definitions below:

1. *Confrontive Coping* (maximum score 15) describes aggressive efforts to alter the situation (" I tried to tell him not to do this to me") as well as a degree of hostility (e.g., "I expressed anger to the person who caused the problem/the person who was touching me") and risk-taking (e.g., "I did something very risky - something I would not normally do").

2. *Distancing/detachment* (maximum score 15) describes efforts to detach oneself (eg., "I didn't think about it too much, tried to forget the whole thing", "I went on with my life as if nothing was happening"). It also includes an element of positive outlook (eg., "looked on the bright side of things, thought of happy times").

3. *Self- Controlling* (maximum score 15) describes efforts to regulate one's own feelings and actions ("tried to keep my feelings to myself", I didn't let anyone know how bad things were")

4. *Seeking social support* (maximum score 15) describes efforts to seek emotional and informational support ("talked to someone to see if it was happening to others as well",

"made sure I was with people who were kind to me" "I asked someone I trusted for advice").

5. *Accepting Responsibility* (maximum score 12) is similar to the subscale in other studies using Folkman and Lazarus' WOC, that of "self-blame". It takes into account the persons own/perceived role in the problem ("I criticized myself"/ "I told myself off", "I brought this on myself") with a concomitant theme of trying to put things right ("I apologised or did something to make things right")

6. *Escape-Avoidance (Wishful Thinking)* (maximum score 21) describes hope /illusion or fantasy (eg., "wished the situation would go away", "hoped a miracle would happen") and behavioural efforts to escape or avoid (eg., "I slept more than usual", "I stayed away from people", "tried to make myself better by eating more, taking pills, drinking alcohol").

7. *Planful problem-solving* (maximum score 18) describes deliberate problem focused efforts to alter the situation coupled with an analytic approach to problem solving (eg., "I made a plan of action and followed it", "I did or changed something so things would turn out right", "I came up with some answer or solution to the problem").

8. *Positive Reappraisal* (maximum score 18) describes efforts to create positive meaning, to posively integrate parts of the experience by focusing on personal growth. It also includes religious beliefs as coping ("I prayed", "I thought to myself that I would be a stronger person because of this").

The remaining Appraisal and Perception items were included at the end of the WOC&AC questionnaire, and were questions requiring a Yes/No response (Appraisal items in previous coping research have been formatted into Yes/ No responses, eg., Vitaliano et al., 1985). The items were compiled by the researcher from literature by Folkman and Lazarus (1984), Folkman et al (1986), Johnson and Kenkel (1991), Mc Crae (1984), Beardslee (1989), Rutter (1984,) and general literature on cognitive appraisal, meaning of events and resilience. Responses were grouped into 6 categories after coding:

1) 'Normal' ie, the child perceived the stressor to be a normal, usual part of growing up, and was something that happened to most people.

2) 'Self Blame' ie., the child perceived the stressor to be somehow connected to a wrongdoing on their part and assumed responsibility for the stressor.

3) 'Interest/challenge' ie., the child was curious regarding the stressor and perceived it to be interesting.

4) 'Loss, harm' ie., the child perceived the stressor to be immediately threatening to their stability either within the family or their personal integrity.

5) 'Expected loss, harm' ie., the child perceived that something terrible might happen to themselves or their family (what Folkman & Lazarus, 1984, refer to as 'threat')

6) 'Stigma' ie., the child perceived and was worried that others would look upon ther/him differently as a result of their experience.

In addition, in order to test external variables of perception of relationship between perpetrator and child for the abuse group, two further appraisal variabes were included:

7) Perceived lack of closeness, like for perpetrator (pre - disclosure) "I did not ever like him" and 8) Perceived love and close relationship with perpetrator (pre - disclosure) "before he touched me, I loved him a lot" . These 2 variables remain separate from the 'relationship prior to abuse and 'relationship post disclosure' variables, which were ascertained in the Demographic and Historic Questionnaire from the therapist's knowledge of the child.

Finally within the WOC&AC, was a Stess Appraisal Scale from 0 to 10, on which the child circled a number indicating her/his experience of stress during the duration of the stressor. This experience of stress was defined as a situation that the child perceives as aversive and taxing (Folkman and Lazarus, 1984). The Stress Appraisal Scale was scored as:

0 - 4 'not threatening'

5 - 6 'mildly threatening'

7 - 8 'moderately threatening'

9 - 10 'extremely threatening'

3. Historical and Demographic Questionnaire (HDQ) (abused group)

This measure assessed demographics, abuse characrteristics and therapist's description of impact of abuse on the child (see Appendices). It was used as a primary measure for identifying factors associated with differential effects of CSA, aside from the child's perceptions and coping during abuse (Conte and Schuerman 1987). Variables covered in this questionnaire included: age of child, family structure, child's current living situation, abuse variables (frequency, duration, type of abuse, type of coercion used) quality and type of relationship between child and perpetrator, disclosure variables (was the child believed, did non- offending caregiver support the child, had the child attempted disclosure previously), court experience, was perpatrator prosecuted, support network during and after sexual abuse, type and extent of therapy, caseworkers assessment of impact of the abuse on the child. Caseworkers' assessment was rated by the researcher, based on their description of the child, into "reasonably well adjusted", "moderate behaviour problems" and "severe behaviour problems".

4. Background Information Sheet (control group)

Parents of the control group completed this brief questionnaire for demographic data, (in aid of matching subjects) as well as their perception of their child's coping strategies, support network and general disposition.

Procedure

A pilot study was conducted to ascertain comprehension of questions and children's reactions to them . Four sexually abused female children between the ages of 8 and 13 participated. All girls comprehended the questions, and alerted the researcher to questions which were "asked before" (which were then modified). These subjects freely

discussed any issues that were significant to them and all 4 girls, who were in the early to middle stages of counselling post -disclosure, expressed how useful they found being able to be talk openly about their experiences, especially in the context that it would benefit other children. The results of the pilot study however alerted the researcher to the difficulties of gaining access to these Ss within the framework of a semi - structured face to face interview, as well as involving nonoffending caregivers, which was the original design of the study. A review with the researcher and academic staff, resulted in changes being implemented to the design of the study into the present one:

Ss were accessed via questionnaires through agencies and hospitals. In order to ensure as high a return rate as possible, give time restraints of caseworkers in this field of work, two questionnaires were eliminated (Piers Harris Self Concept Scale and Parent Form of the Louisville Behaviour Checklist) and one was replaced - the Children's Depression Scale was surpassed by the Children's Depression Inventory.

The following measures then provided the basis of the study:

1) Ways of Coping and Appraisal Checklist, modified from Folkman and Lazarus' (1984) 'Ways of Coping Checklist'.
2) Children's Depression Inventory (Kovacs, 1981)
3) Demographic and Historical Questionnaire (see 'measures').

1. *Sexually Abused Group:*

A mailing list and/or contact names of Child Sexual Assault agencies were obtained for the states of NSW, ACT, SA and VIC. The researcher then phoned and sent out clinical package sets to the Director/Coordinator of relevant agencies (Health Centres, Sexual Assault Units, Hospitals), who had expressed interest in the study from the initial phone contact. Clinical packages included: Cover letter, instructions for caseworkers, research proposal, stamped self-addressed envelopes, 6 copies of the Ways of Coping and Appraisal Checklist, Children's Depression Inventory, Historical and Demographic Questionnaire, and Consent Form. A follow up call was made to all agencies for response to participation, (this was a time consuming process due to respective ethics

board considerations) followed by reminder calls two weeks before questionnaires were due. Caseworkers returned stamped self addressed envelopes to the researcher when they had completed the questionnaires with a client.

A total of 30 agencies were initially contacted and sent packages, which approximated 180 questionnaire sets. Of these, 12 agencies agreed to participate. After an extended period of 10 months, a total of 6 agencies responded by returning completed questionnaires. In total, 26 questionnaire sets were received. Participating agencies were from S.A, N.S.W and A.C.T.

The caseworkers were sent instructions, for standardisation purposes. Each caseworker administered the CDI followed by the WC&AC to the child, noting any signs of discomfort or fatigue, and taking a break or debriefing as needed. It was asked that the session using the questionnaires be part of the child's therapy, and not done in isolation. Following completion of the questionnaires by the child, the caseworker completed factual information in the Historical and Demographic Questionnaire.

When all questionnaires were received, the researcher sought out a matched control group.

2. *Control Group*

Subjects involved in the control group came from 2 sources: 1) The Parents without Partners Support group in Canberra (for matching of children living in 1 parent families) 2) known people of the researcher who had age appropriate children. Responses for the control group were rceived from the A.C.T as well as S.A.

The researcher organised with an administrator of the Parents Without Partners Support group to coordinate completion of questionnaires within the agency.

The control group were sent a consent form, the CDI and WOC&AC (modified very slightly to remove reference to sexual abuse) stamped, self-addressed envelopes, and parents were asked to complete a Background Information sheet for demographic data.

Of the 35 questionnaire sets distributed to potential matched subjects, 18 were initially

received. After follow up phone calls, 12 further questionnaire sets were received. These were then matched for age, sex and family constellation with the abuse group.

When all questionnaires were received, data analysis using the Social Sciences Statistical Package (SPSSx) commenced.

RESULTS

Depression

The sample's scores on the Children's Depression Inventory (CDI) were firstly compared to the Australian published norms reported by Spence & Milne (1987). Their normative data (n = 386) establishes the mean CDI score for ages 7 to 12 as 12.83 (SD = 7.81). This is a higher mean than that reported by American researchers, who obtained a mean CDI score of 9.51 (SD = 7.37) for 7 to 12 year olds (Finch et al, 1985).

CSA group: subjects who were sexually abused in the present study (ages 7 to 15) scored a mean CDI score of 16 (SD = 7.8), higher than both Australian and U.S norms, however not high enough to fall into moderate (>18) or clinical depression range (>24). It must be noted that the present study includes children over the age of 12, for which published normative data appears to be unavailable. Weaver (1986) established a CDI mean of older Australian children (12 to 16) at 7.5 (SD = 4). However the sample size was relatively small (n = 23), and can thus only be used as a comparitive guide.
In the present study, 23% of the sexually abused group's subject's CDI scores fell within the "clinical depression" category; 20% within the "moderate depression" category, and 57% of subjects scored in the "no depression" category, ie., 43% of Ss in the sexually abused group are reported to be experiencing a moderate to severe level of self-reported depression.

Control group: Ss in the comparison group scored a mean CDI of 7 (SD = 6.9), ranging from 0 to 29. Three percent (3%) of the control group scored within the "clinical depression" category; 3% within the "moderate depression" category, and 94 % of the control group Ss scored in the "no depression" category. As compared to the abused group (53%) 6% of control group Ss report themselves to be experiencing moderate to severe levels of depression.

Independent samples t-test results showed a statistically significant difference between sexually abused and control groups for CDI scores, as illustrated in Table 2.

Table 1: *Frequencies for Depression and Threat Appraisals by Group*

Variables	CSA Group	Control Group
Male	23%	23%
Female	77%	77%
No depression	57%	94%
Mod depression	20%	3%
Clinical depression	23%	3%
No threat	0%	34%
Mild threat	11%	30%
Mod threat	19%	19%
Severe threat	69%	15%

Multiple regression analyses were performed with all Ss to determine if appraisal scores and coping strategy types increase predictability of adjustment, using the CDI. Several sets of regressions were run, using internal, cognitive variables, group, age and apraisal score. As illustrated in Table 2, three variables were significant predictors of depression, overall $F = 3.6$, $p < .001$:

(1) 'Group' ie., Ss who have been sexually abused are predicted to score higher on depression (2) Ss who used the coping strategy of 'Accepting responsibility' are predicted to score higher on depression, and (3) Ss who use the coping strategy of 'Distancing' are predicted to score higher on depression. These variables explained 47% of the variance in CDI scores ($r2 = .47$). This analysis had a cumulative r of .68, adjusted r of .34, and standard error of 7.1.

Table 2: Results of Multiple Regression with CDI as the measure of effects, $r^2 = .47$

Variable	B	Beta	t	Significance
Group	-8.57	-.49	-2.8	.007
Resp	.75	.27	1.9	.005
Dist	-.57	-.28	-1.9	.059

Further statistically significant relationships with CDI are reported below.

Table 3: *Group Means, Standard Deviations and t values for Depression and Appraisal*

	CDI				**Appraisal**			
	Mean	SD	t	p	Mean	SD	t	p
Abused group	16.2	7.8	4.54	<. 01*	8.9	6.	5.70	<.01*
Control group	6.9	6.9		< .01*	5.5	2.5		<.01*

* significant

Caseworker's / Therapist's Assessment

Each caseworker informally rated and described their client's adjustment status, based on their expertise in the area of working with abused children (see Method). Twenty seven percent (27%) of Ss were assessed to be reasonably well adjusted. Fifty percent (50%) were assessed to have problem behaviours of a moderate nature, while 23% of Ss were assessed by their therapists to have clinically significant psychological problems, ie., 73% of Ss in this study were assessed by their therapist's as experiencing moderate to severe problems at the time of their work with them. Descriptive analysis shows that children whose therapists assessed them to have significant psychological problems, scored on average in the category of moderate depression (CDI M = 19, SD = 11.5). Those children who therapists assessed as having moderate problem behaviour, scored

just below the moderate depression category (CDI M = 15.6, SD = 6.5). Simple correlation between therapist's assessment and CDI was nonsignificant (r = .19, NS).

Stress Appraisal

CSA group: The mean score for subjects' perception of their experience of CSA as being stressful (0 = no stress, 10 = extreme stress) was 9 (SD = 1.6). Sixty eight percent (68%) of subjects reported their appraisal of the CSA at the time of abuse as "extremely" threatening and stressful; 20% reported the experience as "moderately" threatening and stressful, and 12% of subjects reported perceiving their experience as "mildly or a little bit" threatening and stressful. No subjects in the abused group reported stress levels under 5.

Correlations between stress appraisal score and coping subscales were nonsignificant for the abused group, however a relatively high negative correlation btwn 'Self-Controlling/hold self back' and the appraisal score was evident (r = -.30, NS).

Correlations between appraisal score and CDI showed a statistically non-significant relationship (r = -.22, NS)

Control group: Correlations between appraisal score and coping subscales showed statistically non significant, however relatively high correlations between the appraisal score and coping strategies 'Self controlling/hold self back' (r = 0.35, NS) and 'Escape-Avoidance' (r = 0.37, NS) were evident. Correlations between appraisal score and CDI showed a nonsignificant relationship (r = 0.25, NS).

All groups: Indepenent-samples t - test results established group differences on the stress appraisal score as statistically significant (see Table 2).

Correlations were calculated to examine relationships between subjects' perception of threat and stress associated with the experience, and types of coping strategies subsequently used, irrespective of the nature of the stressor. Correlation analyses showed statistically significant relationships between high threat appraisal scores (9 -10)

and coping sub-scales "Escape - Avoidance" ($r = 0.59$, $p < 0.001$) and "Self Control/Holding self back" ($r = 0.38$, $p < 0.01$). "Confrontive coping" and stress appraisal showed a statistically non-significant correlation ($r = .35$, NS). Correlation analysis between appraisal score and CDI showed a significant relationship - the higher the threat appraisal, the higher the depression score ($r = .37$, $p < 0.01$).

Stress Appraisal Variables

The stress appraisal variables consisted of :

1. whether the child perceived the experience as 'normal'
2. whether she/he took responsibility of the event on her/himself ('self blame')
3. whether the child perceived the event to be 'interesting and challenging'
4. whether the child perceived an experienced 'loss' in the event occurring
5. whether the child anticipated or 'expected harm or loss' to occur
6. and appraisal of 'stigma' by the event.

Independent samples t - test results between the groups are illustrated in Table 4. Findings showed statistically significant differences between the abused and control groups on the variable of 'self blame', in that the sexually abused group perceived themselves as more to blame for the event . Significant differences were also found on the 'interest/challenge' variable, where the control group reported appraising their stressors as more interesting/challenging than the abused group . Perception of experienced loss, expected loss or harm, and a sense of stigma were also statistically significantly in the direction of the appraisals made by the abused group as compared to the control group.

Table 4 : *Means, Standard Deviations and t - test results for Stress Appraisal Variables between Groups*

	CSA Group		Control Group		
Variables	M	SD	M	SD	t
Normal	.38	.49	.31	.47	0.57 ns
Blame	.54	.51	.23	.43	2.36*
Int/challenge	.50	.51	.15	.37	-2.81**
Loss	.65	.49	.12	.33	4.70**
Expect Loss	.96	.19	.80	.40	1.75 ns
Stigma	.88	.33	.61	.49	2.31*

* $p < 0.05$, ** $p < 0.01$

CSA group:

Correlations between 'Stress appraisal Variables' and CDI with the abused group showed statistically nonsignificant correlations between 'self-blame' and CDI (r=.39, NS), and'experienced loss' and CDI (r = .33, NS). Correlations between appraisal variables and coping subscales showed that an appraisal of 'stigma' was significantly related to the coping strategy of 'Distancing' (r = 0.63, p <.001), and an appraisal of 'loss/harm' was significantly negatively related with 'Planful problem solving' (r = -.53, p < .001), ie., the higher the perception of loss, the lower the use of planful problem solving.

Control group: Correlations between appraisal variables and coping subscales for the control group showed significant relationships between the appraisal of 'loss/harm' and 'accepting responsibility' (r = 0.63, p < 0.001) and the appraisal of 'stigma' and 'accepting responsibility' (r = 0.60, p < 0.01). Correlations between threat appraisal variables and CDI showed the higher the experienced appraisal of loss in the control group, the higher the levels of depression, as illustrated in Table 4.

Table 5 : *Correlations between Threat Appraisal Variables and CDI*

	CDI	
Appraisal Variables	Abused Group	Control Group
Normal	-1.22	.26
Blame	.39	.48
Interest	.05	.03
Loss	.33	.77*
Expected loss	.14	.22
Stigma	-.15	.37

* $p < 0.001$.

Table 6: *Correlations between Threat Appraisal Variables and Coping Strategies for Control Group*

Appraisal variables	Coping Subscales							
	CC	Dist	SC	SS	Resp	EA	PS	PR
Normal	-.20	.01	-.04	.21	.14	.10	-.06	-.16
Blame	.02	-.49	.18	.05	.41	.08	.39	.16
Interest	-.16	-.44	-.09	.19	-.10	-.20	.19	-.12
Loss	.27	-.33	.25	.03	.63**	.45	.35	.20
Exp loss	-.20	-.27	.07	-.05	.03	-.14	-.18	.18
Stigma	.18	.17	.42	.14	.60**	.30	.29	.44

sig * $p < 0.001$

Table 7: *Correlations between Threat Appraisal variables and Coping subscales for the Abused Group*

Appraisal Variables	Coping Subscales							
	CC	Dist	SC	SS	Resp	EA	PS	PR
Normal	-.16	.39	.25	.22	.15	.21	.08	.30
Blame	-.26	-.33	-.12	-.40	-.09	.27	-.18	-.30
Interest	-.22	.12	.12	-.16	.12	-.22	.06	-.08
Loss	-.38	-.29	.02	.02	.16	.21	-.53**	-.17
Exp loss	-.14	.30	-.17	-.34	.07	.25	-.13	-.15
Stigma	.22	.63**	.21	-.73	.13	.06	.13	.30

sig *p < 0.001

Table 8 shows the frequencies of "appraisal checklist" responses. These were calculated to give an idea of degree of threat, self-blame, betratal, stigmatisation, loss and so on between the two groups (see Introduction).

Table 8: *Frequencies of "appraisal checklist" responses for the abuse and control groups*

Appraisal	CSA group	Control group
Normal	38%	30%
Self Blame	55%	23%
Interest	15%	50%
Immediate loss	65%	11%
Threat of loss	92%	80%
Stigma	88%	61%

In addition, regarding the variable "Relationship with perpetrator", 30% of sexually abused Ss stated they had a close relationship with and loved the person who touched them. Eighteen percent was missing data, taken to possibly mean that they were not sure, and 52% stated they did not feel they ever had a close relationship with the perpetrator, or ever loved him. A Pearson's correlation analysis showed a statistically nonsignificant relationship between the quality of relationship between child and perpetrator prior to the abuse and CDI ($r = .14$, NS).

Coping

As illustrated in Table 9, subjects in the abuse group used all coping strategies more often than the control group - the exception being 'social support', where subjects in the control group were more likely to use this strategy. It is interesting to note that confrontive coping, as illustrated in Table 10, was used significantly more in the abuse group than the control group. Statistically significant differences also included Ss in the abuse group using the coping strategies of Distancing, Escape-Avoidance and Self-Controlling more often than Ss in the control group.

Table 9: *Frequency of Use of Coping Subscales ('often' and 'all the time') by Group*

Coping Scale	CSA Group	Control Group
Confrontive	50%	30%
Distancing	76%	38%
Self Control	65%	46%
Social Support	30%	57%
Accepting Resp	42%	30%
Escape-Avoidance	96%	42%
Problem solving	53%	50%
Positive reappraisal	42%	38%

The significant differences in useage of coping strategies between groups are presented in Table 10.

Table 10: *Means, Standard Deviations and t statistics on the Ways of Coping Checklist between groups.*

	CSA Group		Control Group			
Coping Subscale	M	SD	M	SD	*t* value	*p*
Confrontive coping	7.7	3.3	5.8	3.0	2.14	<.05 *
Distancing	11.1	4.1	7.8	3.6	3.01	<.05 *
Self Controlling	9.4	3.1	6.0	2.9	4.02	<.01 *
Social support	6.2	4.1	7.0	4.1	-.71	ns
Self blame	5.1	3.2	3.8	3.0	1.56	ns
Escape - Avoidance	14.0	2.5	9.0	3.5	5.94	<.01 *
Problem solving	7.4	3.9	6.7	4.3	.68	ns
Positive Reappraisal	7.7	3.8	6.9	3.4	.85	ns

* significant $p < 0.05$, $p < 0.01$.

CSA group: Correlations between appraisal score and all 8 coping sub-scaleswas statistically nonsignificant, as illustrated in Table 10. Correlations also showed that within the CSA group, types of coping strategy were not related to depression scores.

Control group: Correlations between appraisal score and coping subscales was statistically nonsignificant (eg., 'self-controlling/holding self back' and appraisal ($r = .35$ NS) and 'Escape-Avoidance and appraisal score ($r = .37$ NS). Correlations between coping subscales and CDI for the control gp showed a statistically significant relationship between 'accepting responsibility' and CDI ($r = 0.5436$, $p < 0.01$) and a relatively high but nonsignificant correlation between 'Escape-Avoidance' and CDI ($r = 0.34$ NS).

All groups:

Correlations analyses to determine whether coping style was related to functioning(CDI) indicated that : Including all 52 subjects, correlation analyses yielded statistically significant relationships between CDI scores and "Escape- Avoidance" ($r = 0.48$, $p < 0.001$), "Accepting responsibility/Self Blame" ($r = 0.38$, $p < 0.01$), and "Self - Control/ Holding self back" ($r = 0.39$, $p < 0.01$). Interestingly Escape-Avoidance and Self Control were also significantly correlated with subjects' appraisal of threat score (see Stress Appraisal).

Analysis of variance indicated that there was a significant main effect for CDI and "Accepting Responsibility" ($F = 2.151$, $p < 0.05$) and"Escape-Avoidance" ($F = 2.631$, $p < 0.05$), ie., the variance in all Ss' CDI scores is explained by variance in the coping subscales "Accepting Responsibility" and "Escape-Avoidance".

Multiple regression analyses were performed in the CSA gp to determine:

a) if a combination of any of the 8 coping strategies increased the predictability of adjustment

b) if any "external" variables (eg., perpetrator, type of CSA, events surrounding disclosure etc) predicted the child's adjustment/outcome

c) if appraisal was a predictor variable re outcome.

Multiple regression analyses results were statistically nonsignificant on all of the above, undoubtedly due to the sample size of 26 in the CSA group (See Discussion).

A statistically significant model however was established for the whole sample of 52 Ss, using internal cognitive variables as predictors of psychological outcome (see above"Depression")

Table 11: *Correlations between Coping, Stress Appraisal and CDI for Abused Group, Control Group and Both Groups.*

	CSA Group		Control GP		Both Groups	
Coping	Stress Appr	CDI	Stress Appr	CDI	Stress Appr	CDI
Confr	.30	-.06	.18	.02	.35	.16
Distan	-.25	-.20	-.15	-.11	.11	.09
S -C	-.30	.04	.35	.33	.37*	.39*
Soc S	.15	-.18	.17	.04	.06	-.15
Resp	.10	.13	.14	.54*	.23	.38*
E -A	.19	.05	.37	.34	.59**	.48**
Probsol	.03	-.13	.06	.28	.10	.11
P reapp	-.02	.14	.27	.26	.19	.22

sig * $p < .01$, ** $p < .001$

Perpetrator

All perpetrators were male. Sixteen percent (16%) of all subjects were sexually abused by more than 1 perpetrator, the second perpetrator usually being a friend of the initial perpetrator who was a family member.

Of the total sample, 68% were sexually abused by a family member (intra-familial); 32% by a person outside the family (extra-familial). Fifty four percent (54%) of subjects were abused by a father figure i.e., 31% by their biological father, 19% by their step-father or mother's de facto, and 4% by their adoptive father from birth. Twelve percent (12%) were sexually abused by their grandfather. Of the remaining sample, 16% were abused by a friend of the family, 12% by their neighbour, 4% by their brother and 4% by their cousins.

Analysis of CDI means by who the perpetrator was showed that the highest mean CDI score was for subjects who were sexually abused by their father (M = 18, SD = 9.4), followed by subjects who were abused by their stepfather or mother's de facto (M = 16, SD = 10).

Relationship between perpetrator and subject before and after abuse

Thirty eight percent (38%) of subjects' therapists reported that their client experienced a close relationship with the perpatrator prior to the abuse, 34% reported a reasonably good relationship and 26% reported a poor relationship. Analyses of Mean CDI scores with relationship prior to CSA showed the Mean CDI scores as being 14 (SD = 3.5) for subjects who had a very close relationship, 19 (SD = 8) for those experiencing a reasonably good relationship, and 16 (SD = 11) for those subjects who experienced a poor relationship prior to CSA.

Eighty percent (80%) of subjects' therapists reported that the child currently "hates" the perpetrator, post disclosure (M CDI = 17, SD = 7.9), 15% of subjects' therapists

reported that the child has a "love/hate" relationship and is confused about her feelings toward the offender (M CDI = 11, SD = 6) and 3% reported that the child still likes the perpetrator (M CDI = 13, SD = .00, n = 1).

Type of sexual abuse

Fifty two percent (52%) of subjects experienced more than one type of sexual activity. Of these 52%, Ss reported vaginal intercourse, anal intercourse (n = 4, equal distribution male and female), oral penetration, reciprocal oral sex, open - mouthed kissing, reciprocal masturbation, and 8% were forced to also watch the perpetrator engage in sexual activity with other people. Forty eight percent (48%) reported one type of sexual activity: vaginal intercourse, masturbation or "touching" and digital-vaginal penetration. The most common sexual activity perpetrated upon subjects was masturbation (66%) followed by vaginal and/or anal intercourse (32%).

Irrespective of type of sexual activity, mean CDI score fell within the 'no depression' range, the highest mean CDI score being for subjects reporting genital touching or masturbation (M = 15, SD = 8), followed by vaginal/anal intercourse (M = 14, SD = 9.6) and digital penetration (M = 14, SD = 10).

Duration

Thirty two (32%) of children were sexually abused between 1 and 2 years; 16% were abused between 3 and 4 years; 28% were abused between 5 and 10 years (12% of subjects were abused for a total of 9 - 10 years); 20% for a few weeks (ie 2 - 4 weeks) and 4% were abused on one occasion. The correlation of duration of CSA and CDI is nonsignifiant (r = -.02 NS).

Frequency

Children who experienced CSA on a regular, frequent basis were on average 12 years old (M = 12, SD = 4). Eight percent (8%) of subjects were sexually abused every day or every other day; 20% were abused once a week; 16% were abused fortnightly; 16% of subjects were abused monthly; 40% experienced between 1 and 6 separate incidents. Correlations of frequency of CSA was and CDI was nonsignificant (r = .26, NS).

Coping Strategies and frequency/duration of abuse

The highest use of 'confrontive coping' occurred for infrequent (ie, 3-6 times) and monthly incidents of abuse, and abuse that was short in duration (a few weeks). Subjects who were subjected to CSA frequently, ie daily (M = 4.5, SD = 2.1) and weekly (M = 6.2, SD = 3.8) and over many years, ie., between 6 and 10 years (M = 6, SD = 2) were least likely use 'confrontive coping' (maximum score 15).

'Distancing/detachment' (max score 15) was a frequently used coping strategy irrespective of frequency of abuse (eg., weekly M = 11, SD = 3, monthly M = 11, SD = 2.3). Subjects however who experienced CSA once (n = 1) do not report using this strategy - rather she/he reports frequent useage of 'confrontive coping' on the sole occasion of CSA.

The coping strategy 'Self-controlling' (max score 15) was most frequently used by subjects experiencing CSA daily, (M = 9, SD = 4) fortnightly (M = 10.5 , SD = 3) and between 3 and 6 times in total (M = 10.8, SD = 3). It was also commonly used by subjects who experienced CSA between 5 and 8 years in duration (M = 11, SD = 2) between 1 and 2 years (M = 9, SD = 3) for a few weeks, (M = 10, SD = 4) and once (M = 12, SD = 0).

'Seeking social support' was least used by those who experienced CSA frequently, ie., weekly and fortnightly (M = 4, SD = 4; M = 4, SD = 1.2) One S who was abused daily used it often (M =12)

'Accepting responsibility' (max score 12) was most frequently used by subjects who experienced abuse daily (M = 6, SD = 1.4) and 3 to 6 times in total (M = 6.5, SD = 3.5) as well as by thos Ss whose abuse lasted for a total of a few weeks (M = 7, SD = 3).

'Escape Avoidance' (max score 21) was the most frequently used coping strategy, irrespective of frequency or duration of abuse (eg., weekly M = 14.4, SD =2.8; 3 - 6 times M = 13.5, SD = 2.7; 6 - 8 years M = 14.7, SD = 1.5, several weeks M =15, SD = 2.5).

'Planful problem solving' (max score 18) indicated infrequent use as a coping strategy. It was highest for those subjects who experienced CSA infrequently, ie between 3 and 6 times (M = 8.5, SD = 2.5).

'Positive reappraisal' (max score 18) was most frequently used by one subject who experienced CSA between 5 and 6 years (M = 15, SD = .0,) followed not as frequently by Ss who experienced it between 3 and 4 years (M = 9.2, SD = 5.2). It was least used by subjects who underwent CSA between 6 and 10 years (M = 5.5, SD = 3) and by one S experiencing it once (M = 5, SD =.0).

Support/belief from primary parent post-disclosure

Ninety six percent (96%) of primary caregivers were mothers, 4% were fathers. Twelve percent (12%) of primary caregivers did not believe, and thus did not support their child post-disclosure. Twenty percent (20%) of caregivers superficially supported their child, ie., stated to the child and authorities that they believed the child, however behaved inconsistently in terms of taking protective action and maintaining a stance of support (eg., by continuing to invite the perpetrator to the family home, encouraging the child to

recant their disclosure). Sixty eight percent (68%) of caregivers believed and fully supported their child post-disclosure.

Analysis of Mean CDI by the variable of 'support from nonoffending caregiver', showed that children who received complete support from their nonoffending caregiver had lower Mean CDI scores (M = 15, SD = 5.7) than children who received minimal or no support (M = 19, SD = 11) from the nonoffending caregiver.

Coercion

Forty percent (40%) of Ss were threatened with danger to themselves or significant others, and/or family breakdown if they did not cooperate. Twenty eight percent (28%) of subjects experienced physical abuse as part of their living environment and in conjunction with sexual abuse; 16% were promised gifts, unconditional love, attention and special privileges; 8% were told that they were to blame and would be punished if they told; and 8% were directed to perform the activities and did so because they saw the perpetrator as an authority figure -in these cases no overt threats were used.

Analyses of mean CDI scores and 'types of coercion used' showed mean CDI scores being highest for Ss who also experienced physical abuse (M = 21, SD = 4.7). The remaining classifications were in the 'no depression' category, irrespective of type of coercion used, although scores are relatively high, the highest being a Mean CDI score of 17 (SD = 9.2) for subjects who were bestowed with attention, gifts, expressions of love from the perpetrator.

Court Outcome

A significant factor which is known to influence the child's prognosis after CSA is a sense of justice and safety. Thirty one percent (31%) of cases did not go to court because the child and/or caregivers did not want to lay charges; 27% of cases were prosecuted and sentenced; 23% went to court and are awaiting court outcomes; 15% were rejected

as court cases because of insufficient evidence and/or denial by the perpetrator, and 4% of cases the perpatrator was prosecuted but acquitted.

Analyses of mean CDI by court outcome showed a high mean CDI score of 'moderate depression' where the case did not go to court because of insufficient evidence (M = 18, SD = 10.5) followed by the case not going to court because the child did not lay charges (M = 17, SD = 5.3).

Gender and CDI

Females scored higher (M = 12.1, SD = 8) on the Depression Inventory than males (M = 9.5, SD = 9). An Analysis of Variance showed that CDI varies with gender ($F = 2.82$, $p < 0.01$).

Age and CDI

No statistically significant associations beween age and CDI were evident (r = .24, NS). Analysis of Mean CDI by age showed in general, that older children had higher depression scores (eg., 13 year olds M = 24.3, SD = 5.5) than younger children (eg., 9 year olds M=13, SD = 4.2). Twelve year olds (the Ss most frequently sexually abused) fell into the moderate depression range (M = 18.8, SD = 2.2). Eight year olds were the only other age group that fell into the moderate depression range (M = 19, SD = 7).

DISCUSSION

The study was undertaken firstly to investigate how children who have been sexually abused appraise and cope with their experience, based on the cognitive behavioural model of stressful events being determined and mediated by cognitive processes. Secondly the aim was to examine if this could explain or mediate psychological outcome, specifically the well recognised and empirically documented consequence of depression. The process of appraisal and coping and psychological outcome was compared with a matched control group, who had experienced significant 'everyday' stressors.

The stress and coping mediational model proposed by Lazarus and Folkman (1984) was partially supported, however more so with the control group. The current study demonstrated that stress appraisal scores and appraisal variables and coping in both groups are significantly related, however no association was evident between CSA appraisals and psychological outcome (CDI). Importantly, results confirm previous studies on cognitive appraisal and coping that show that variability in coping is partially a function of people's judgements about what is at stake in specific stressful encounters (eg., Folkman et al., 1986, Johnson & Kenkel, 1991).

Firstly it was necessary to establish if sexually abused children actually perceived their experience as stressful. Results indicated that the majority of sexually abused children perceived their experience of sexual abuse as extremely stressful and threatening - significantly more so than the control group. This perception of threat and stress however was not related to the outcome variable of depression for the abused group, although results for both groups, irrespective of nature of stressor, showed that high depression scores were related to high stress appraisal scores, which supported the hypothesis.

The second hypothesis was that stress appraisal variables would be related to specific coping strategies. Specifically, it was predicted that children using the appraisal

variables of "loss", "stigma" and "self-blame" would use avoidance strategies most. This was partially supported. Results from the abuse group indicate that children who perceived their sexual abuse as involving stigma - in other words, shame, feeling like they do not belong etc, were more likely to use Distancing or Detachment to cope with their situation. It would be worthwhile to undertake a longitudinal study on this, to see if in fact children who appraise the CSA as involving stigma, but who use other ways of coping, have a different long term outcome. It is interesting to note the almost similar response by the control group. Children in the control group who appraised their situation as involving loss as well as stigma, coped by accepting responsibility or blame for the stressful situation -what Janoff -Bulman (1979) calls "behavioural self - blame". As discussed in the Literature Review a degree of self-blame, especially behavioural self blame, according to Janoff- Bulman and Frieze (1983) is a way the individual can take and maintain control of a situation, which is useful. The researcher predicted that in fact self blame would be related to higher depression scores in the abuse group precisely because the blame is not based in reality.

This relates to a further hypothesis that the way the child appraises and subsequently copes with a stressful situation, will be associated with psychological outcome. There was no association with appraisal of self blame, coping or depression in the abuse group, however results indicate that the variance in the CDI scores for the whole sample is explained by the coping strategies Accepting responsibility and Escape Avoidance and in fact, the only significant relationship for the control group between CDI and coping is accepting responsibility (r =.54), which , as mentioned above, was also related to appraisals of stigma within the control group. This lends some support to the prediction that self blame may not be a useful way of appraising or coping with a situation. Keeping in mind Hegelson's (1992) point that unless the blame is based in reality, it will not be helpful, the many stressors of children in the control group consisted of parents fighting, separating or having had a divorce, so it is possible that these children shouldered responsibility for these situations. Alternatively children's acknowledgement for "reality - based blame" (eg., causing an argument with a best

friend) may be justified, but simply not as helpful or useful as other coping stategies. Frydenberg and Lewis (1991) found that within their Australian sample of 500 adolescent students, the conceptual area of Self Blame (and Wishful Thinking) were not coping means which were spontaneously reported by Australian students. Thus, despite it being a strategy used in the present sample, conceptually it may not have really "fit", with their situation.

Johnson and Kenkel's study (1991) showed that adolescents who showed the greatest amount of global psychopathology coped by means of 'detachment/distancing', which they describe as different from dissociation, and more a form of cognitive resignation and conscious "denial". Subjects with whom the researcher had face to face semi-structured interviews supported this "conscious" definition of Detachment: "It's like a dream - you put it away and don't think about it ...I felt it doesn't matter, it's not really happening" and another :" I handled it by numbing out, by not thinking about what was happening...It's there but you shut yourself off", "I felt like I was sort of 2 people, because the rest of my life I'd written down (diary) and not that". This point raises important therapeutic questions, regarding developing helpful strategies and changing less helpful ways of coping (post-abuse), being aware that detachment may eventually become less consciously controlled:

"...dissociation may originally develop as a way to cognitively disengage from aversive stimuli during abuse episodes, later becoming a more autonomous symptom which is elicited under a variety of stressful circumstances" (Briere and Runtz, 1988, p. 55).

The current findings confirm previous research findings, eg., Armistead et al., (1990) that Distancing and Escape-Avoidance are coping starategies which are associated with higher depression scores. It is not possible to say from the results whether the CSA group found them to be helpful strategies, and there was no association between these "avoidance" or "emotion-focused" strategies and CDI in the abuse group.

A further hypothesis predicted that the ways the sexually abused child uses to cope with the stressful event would mediate depression scores. A direct relationship

between the ways of coping used by sexually abused children and depression was not evident from the analysis with the abuse group. However this was not because of a lack of associations between the appraisal measure and coping measure, as results showed significant relationships between appraisal variables and coping in both groups. In fact the direction of the correlation was negative ($r = -.22$, ns), ie., the more the children perceive their abuse as threatening, the less depression they are reporting to be experiencing. This could possibly be due to "sleeper effects" - in which the child does not experience any effects or symptoms, such as depression, until after a few years later , when a trigger or situation related to the abuse brings on powerful emotions and behaviours. Some questionnaires revealed horrific and constant abuse which continued over several years, yet these children reported CDI scores of under 3 ($n = 2$). Other children spoke of one off or short duration abuse, and scored within the clinical depression range. These scores may be a tue reflection of the child's state, in other word's as Basta & Peterson (1990) stated, the fact that CSA occurred is enough to cause damage with some children, irrespective of duration, frequency or type of sexual contact. A further possibility is that the children who have experienced CSA over a long period may have become desensitised or have learnt to dissociate.

It may also be that coping and depression were not related in the abuse group because of problems with the sole outcome measure employed, besides the fact that it was just one outcome measure. The Children's Depression Inventory requires the child to self-report feelings and thoughts honestly in response to quite confrontational questions or statements - children who have been sexually abused may not want to report their feelings, may not be aware of what/how they are feeling, especially if they have learnt to dissociate, or they may genuinely not be experiencing the feelings described on the CDI. This last statement however, in the light of CDI scores being higher both than Austaralian published norms, and the control group, is not as likely.

An interesting relationship was found with those children who perceived their sexual abuse as involving loss and or harm and their lack or infrequent use of Planful Problem Solving as a coping strategy, ie., the higher the perception of loss, the less these

children used problem solving to deal with the situation. Maintaining the link with 'depletions of self', or loss as being associated with depression, theoretically this finding may be linked with Seligman's Learned Helplessness model - that these children may have learnt or decided that they could do little to stop the CSA (unless they disclosed) , thus they did not overtly try - perhaps not using confrontive coping was was more helpful. As a couple of children in the pilot study said: " I wanted it to stop - I didn't feel I could do anything to stop it ...he used to hit us - he was the one in control. I was upset that I didn't have a say in it, but I thought 'this is just the same as the other things (that I didn't have a say in)' " and the same child "I locked it away, and thought noone's going to believe you". From another child: "He was old (ie., child's grandfather), and he was nice to me, so he did it whenever he wanted to, usually when I was asleep, so I just pretended to keep sleeping, hoping that he would stop" the same child "I was afraid mum wasn't going to believe me". Regarding the hypothesis that because CSA is inherently "unchangeable" or independent of what the child attempts to do to stop it (except disclosure), children were more likely to use "nonconfrontive" ways of coping. Data show this is in fact so - the CSA group uses Escape-Avoidance and Distancing/Detachment more than any other strategy, however there were no significant correlations with abuse group between these emotion focused strategies and CDI. This hypothesis is informative regarding the findings of Folkman, Lazarus, Dunkel - Schetter, DeLongis and Gruen (1986) who found that subjects who perceived stressors as having to be accepted (as compared to changeable encounters) used Distancing and Escape -Avoidance to cope. Those encounters on the other hand that were perceived as changeable, were dealt with by problem - focused coping strategies (planning, problem - solving, confrontive coping).

As Collins et al (1983) indicate, distancing may be an adaptive response to a situation that is seen as negative and unalterable.

The loss hypothesis was supported by the control group, rather than rhe abuse group - those children who perceived their stressor as involving loss/harm had higher depression scores. In fact this relationship between loss and depression was the

strongest within all correlations calculated (r = .77). Although the majority of children (65%) in the abuse group perceived loss, they demonstrated a nonsignificant relationship with the measure of depression, although a relatively high correlation (r = .33). Interestingly, a higher proportion of children in each group *expected* that harm or loss would occur as a result of their experience, (CSA 92% and control 80%) however appraisal of expected harm or loss had no association with depression. This difference is noteworthy in itself. More children, overall, perceived a threat to come in the near future rather thean perceiving immediate, current loss or harm, however overall the perception of immediate loss was more powerful in terms of relationship with depression. This supports findings by Hammen and Goodwin - Brown (1990) who's results showed a significant association between onset of depression in children and appraisals of depletions to the self (ie., loss, harm) in their sample of 8 - 16 year old children. Self concept, or meaning of self was especially relevant in their research.

The researcher of the current study expected the abuse group to have a similar relationship, as it was expected that CSA, based on previous findings, particularly by a caregiver or multiple perpetrators, would be especially meaningful to the child's sense of self. "Self -esteem is shown to be powerfully affected. Insofar as the comparison group had also experienced severe family difficulties, this result highlights how devalued the girls in the incest group perceived themselves to be" (Hotte and Rafman, 1992). This is consistent with regards to the association of a father -figure being the perpetrator and high mean CDI scores in the present study: "This low self-esteem may support the view of many authors that the betrayal by parents who should be the child's protectors rather than her exploiters severely impairs her self-confidence, basic trust and consequent self-image" (p. 281). It is worthwhile to note that 'Self Blame' appraisal and CDI scores were relatively highly correlated (CSA r = .39 and Control r = .48) suggesting the potential association. It is also possible that similar limitations of the present study's single measure applies here, and that sexually abused children experience other emotions more strongly, or more recognisable to them, than depression. For example, it would have been very useful to have a teacher or therapist complete a standardised

questionnaire, however, as discussed in the "Method" this was beyond the scope of the present research. Interestingly, children whose therapists assessed them as being reasonably well adjusted, scored 1 point below (CDI M = 14.8, SD = 7) the children n who they assessed as having moderate behaviour problems CDI M = 15.6, SD = 6.5). The other possibility is that the process of "denial" (CSA children used Escape Avoidance most to deal with their experience) distorts their responses to the CDI.

An expected significant finding was that children who perceived their situation as highly threatening had higher depression scores. This supports the hypothesis that high stress appraisal, ie., perceiving the situation as threatening and likely to be damaging, will be more likely to result in depression than children who do not perceive their event as threatening. Children who perceived their situation as being highly threatening tended to cope by attempting to avoid or emotionally escape from their stressful experience by using the coping strategy 'Escape - Avoidance' (which also supports the hypothesis). Highly threatening situations were also dealt with by these children by controlling their emotions and internalising their feelings (eg., "did not let anyone know how bad things were"), which was the coping strategy of 'Self Control'. This supports Johnson and Kenkel's (1991) findings that children who used 'wishful thinking' (which correlates with escape - avoidance) and 'holding self back/self control' scored higher on distress measures. Overall, Ss within the whole sample who used 'Escape-Avoidance', 'Self-Controlling' and 'Accepting Responsibility' frequently had higher depression scores than childrenn who did not use these strategies. This is consistent with previous studies on dperession and 'avoidance' approaches to coping, eg., Coyne, Aldwin and Lazarus (1981) found that depressed adults consistently used more wishful thinking than nondepressed Ss, and Vitaliano (1985) found a similar pattern for anxiety. Children in the sexually abused group who had high stress appraisals also used confrontive coping - this was a relatively high correlation (r = .30, ns) and suggests a relationship. Future work on the effectiveness of this coping strategy in dealing with CSA would be useful.

Seeking Social support was generally not a primary coping strategy for these children, although the control group used it slightly more often than the CSA group. This has interesting implications, as some researchers indicate that help seeking in some contexts seems to be a dysfuntional coping behaviour (Husiani et al 1982, Pearlin and Schooler, 1975) - (remembering that social support is different from playing with friends in this context) suggesting in fact that the sample of children in this study may have been skilled copers, who utilised a repertoire of other coping behaviors. In fact, it follows that the CSA group did not rely on this strategy as their already perceived sense of stigma may have been magnified either by people's disbelief, or their real fear of break up of the family should they have asked someone for advice. This result is consistent with Folkman, Lazarus, Dunkel -Schetter, De Longis and Gruen's (1986) findings that people sought less social support in encounters that involved their self-esteem, whether it be due to shame or embarrassment. Seeking social support however would be a useful strategy or skill once the child decided to disclose.

Results indicate that the fact that children had been sexually abused contributes to CDI scores, as the matched control group had significantly lower depression scores (9% total 'moderate' and 'clinical' depression); also the abuse group scored higher on the CDI than the Australian and American published norms. A further consideration when interpreting results is the possibility that the control group sample simply may not have been sufficiently stressed by their experience to be included as an adequate control group, despite the fact that children and parents themselves acknowledged that the child's stressor was relevant and significant. Their relatively low stress appraisal scores (M = 5, max score 10) may be due to a number of reasons, however, the researchers' suggestion is that because CSA appears to be an all encompassing, invasive, continuing and uncontrollable event, it is inherently different to 'everyday' stressors, which are likely to be one off events, or situations with a very clear beginning and end, and thus the

task of finding a true, equally pervasive stressful matched sample proves very difficult indeed.

What appears to emerge from the data is that "minor" and infrequent, short incidents of CSA are, according to this population, equally stressful and threatening, as CSA which continues frequently over several years. This may also explain the highly reported use of 'Distancing' as a coping mechanism, irrespective of frequency, duration or nature of abuse. Whether the frequency of abuse was once in total, or weekly over several years, appraisal scores show the experience to be perceived as highly threatening and stressful. Similarly, whether the duration of abuse lasted over one incident, a few weeks or for 10 years, the mean appraisal of stress and threat is 10, for these three categories. This data supports Basta & Peterson's findings (1990) that the fact that sexual abuse occurred is a sufficient reason to elicit stress and distress in children.

An important point to be considered when interpreting the results is the recognition of 'problematic' features that may have been present in the child's environment prior to the CSA. Some children were physically abused as well. We do not know whether the child had problems prior to study, as it is near impossible to undertake a baseline measurement with a resarch area such as sexual abuse - even if a baseline was established, it is difficult to know if the baseline is pre-abuse or not - or had the abuse begun while the child was an infant or toddler? (eg., one S's therapist reports that her adolescent client's recent sexual abuse by mother's de facto brought back memories of a rape by an uncle when the child was 3). Despite the factor of "pre-abuse problems" being an immediate question raised with most CSA research, it is important to recognise recent studies' clear delineation of the impact of sexual abuse on victims vs the impact of dysfunctional families (eg., Hotte & Rafman, 1992).

The results of this study support Johson and Kenkel's (1990) in that they did not indicate that demographic and abuse characteristics (eg., frequency, duration, type of

abuse) were associated with self reported adjustment post-disclosure, contrary to studies showing that these variables play a major role (eg., Finkelhor, 1979, Browne and Finkelhor, 1986, Conte and Schuerman, 1987). Results of the current study also compare with Leitenberg et al's (1992) findings of women recalling their sexually abusive experiences. Leitenberg et al (1992) showed that women who were sexually abused as children reported frequent use of avoidant coping strategies which they stated were helpful at the time. However these women had scores of greater current psychological distress, indicating that the use of avoidant coping strategies is in fact associated with poorer adult psychological outcome (remembering that a relationship between these coping strategies and CDI in the abuse group was not established in the present study).

Limitations of the study

It is suggested that some caution be taken in interpreting the results that have been presented. Because the results are correlational in nature, causal statements and implications must be tempered. Longitudinal data are nedded to address directionality and causality. However results do show that relationships between appraisal variables and coping exist.

It would have been extremely useful to have a larger CSA group to perform statistical analyses in which a combination of predictors could be explained, eg., those children who have high stress appraisals of CSA and, for example severe abuse, yet low psychological outcome measures, was it due to abuse characteristics (if so, which) or cognitive variables (if so, which) that mediated depression scores? This question would have been applicable in the present sample had the numbers been larger.

Some of the "abuse characteristics" ("external variables") were not entered into correlation analyses because the data was categorical in nature with no meaning in values of coded numbers. This to some extent limits the emphasis one can place on cognitive

variables as mediating factors, however those abuse characteristics which were statistically analysed were nonsignificant.

There are limitations in using one psychological outcome measure, and a more rounded perspective on how coping may have mediated other known psychological effects of CSA would have been useful. However the reasons for the use of the sole measure have been discussed (see "Method").

It would have been useful to have an objective measure of the "effectiveness" of children's coping strategies when dealing with CSA to determine how helpful the child's coping starategies were at the the time.

Conclusion

Overall, children who were sexually abused had significantly higher scores of depression than children who were in the control group. They also demonstrated significantly higher 'threat' appraisals than Ss in the control group. As predicted, the 'abuse' group utilised the coping strategies of "distancing" and "escape-avoidance" more than the controls. Sexually abused children in particular appraised their situation as involving stigma and shame, blamed themselves for the situation, perceived the abusive experience as involving loss, coped by distancing themselves and "escaping" from the situation, and were less likely to use planful problem solving, specifically if they appraised the situation as involving a loss. Over three quarters of the sexually abused sample were rated by their therapists as experiencing moderate to severe problems at the time of their work with them.

Ways of appraising and coping with the situation in the 'abuse' group did not predict psychological adjustment as measured by the depression inventory. Statistically, coping strategies for sexually abused children were not related to depression, however when Ss were combined, children who used the coping strategies "distancing" and

"accepting responsibility" had higher scores of depression. As sexually abused children used these strategies consistently more often than the control group, it may suggest that should there have been a larger sample in the abuse group, these strategies may have been related to feeling depressed for sexually abused children. It would be a useful hypothesis to pursue for future research.

The identification of specific appraisal types and coping responses that mediate or fail to mediate the psychological consequences of CSA has tremendous implications for validation of indicators of abuse and therapeutic work with sexually abused children (e.g., investigatory assessments, assessments of impact). This study shows that most sexually abused children in this sample perceived their experiences as highly threatening, and coped primarily by distancing themselves from the situation. The study also shows that children's appraisals overall are related to the way they cope with stressful events and gives an indication of how appraisal and coping might mediate depression.

Future Research

Refined measures of the particular impact of interpersonal events (for children) and more sophisticated measures of cognitive appraisal of child sexual abuse would be useful to establish, given that the most informative methods (eg., interviews) are very useful but time consuming.

Perception of control would be an important area to examine, eg., it may be that CSA children in this sample, are using Escape-Avoidance and Distancing, to establish control over their emotions (what Lazarus &Folkman, 1984, call emotion-focused coping), as they may be usefully acknowledging that they cannot gain overt control over the event (ie., problem-focused). To reiterate Wortman & Dintzer's (1978) point: " We believe that many of the behaviours associated with helplessness...are maladaptive only

when the outcome in question is controllable or modifiable. If the outcome is truly uncontrollable, these behaviours may be highly functional" (cf. Weiss, 1971, p.87).

There exists the possibility that children experiencing CSA do not use active problem solving coping strategies because inherently the nature of CSA is out of their control - like domestic violence, it is independent of the victim's attempts to make the situation better. Thus it would also be useful for future research to examine or measure issues of "control" and "controllability" and "uncontrollability" of stressors associated with CSA, as this has not yet been empirically researched. Victimisation research (eg., Pynoos & Eth, 1985) shows that "intolerable danger", "overwhelming threat" and "helplessness" are key issues with victims. Are children who perceive CSA as such at greater risk of "dissociation", or at risk of maintaining learnt behaviour in the abusive situation indiscriminately to other situations where it is inappropriate? Would using more "active" problem-solving strategies to deal with child sexual abuse, as literature suggests with adult and adolescent groups, in fact be more beneficial in the long term? Or are the child's 'emotion- focused' coping starategies, such as Distancing the only helpful strategies at the time, assuming that children do perceive it as uncontrollable? Given the knowledge that "avoidance" coping strategies potentially can become maladaptive and unhelpful, that most children who are sexually abused use these strategies, and accepting research on the psychological consequences of CSA, the implications for mental health issues are concerning. An undersanding of what coping strategies and subsequent behaviour the child is bringing to therapy, as well as how the child may have come to use and rely on these strategies, is critical for therapy in which the child can incorporate more helpful strategies without necessarily losing the strategies that helped her/him most at the time. A longitudinal study on the appraisals of "controllability" and subsequent coping behaviours would be extremely useful theoretically and therapeutically.

APPENDICES : Clinical Packages (1) ABUSED GROUP

INSTRUCTIONS FOR CASEWORKERS

1. During a session with the child, explain the project, saying that her answers would help other childen who have also been touched/sexually abused.

2. Ask the child and her caregiver to sign the consent form, assuring them of strict confidentiality. Please do not send these forms back, as we are adhering to rules on complete anonymity. All questionnaires will be coded.

3. During the session, explain to the child how to complete the 2 questionnaires, without naming the Depression questionnaire.
Please specify that it is essential to answer all questions, as honestly as possible, and to ask you should they have any difficulties.

4. Administer the Children's Depression Inventory to the child first, followed by theWays of Coping Checklist. At the end of the Coping Questionnaire is a scale measuring the child's level of stress **at the time of abuse** - please explain to the child how this scale works (ie., 0 = not at all bothered/unhappy about it, 10 = very bothered/unhappy about it).

Both questionnaires together should take the child between 60 and 90 minutes. It is a good idea to ask the child if she would like a break for a few minutes halfway through the 2nd questionnaire, which is quite lengthy; some children prefer not to stop, others appreciate a short break.

5. When you as the child's caseworker, have completed the Historical and Demographic Questionnaire (should take approx. 20 mins), please place all 3 questionnaires into the stamped, addressed A4 envelope. These envelopes are weighed for 3 lots of 3 questionnaires, i.e., 3 children having completed 3 questionnaires each.

The results will be forwarded on to your team Coordinator/Director as soon as possible.

Thankyou for your valuable time, assistance and interest.

The Australian National University

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Telex AA62760 NATUNI
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CONSENT FORM

I ..... hereby consent to my child,

..... participating in the research project on coping strategies in sexually abused children.

I understand this involves my child completing 2 paper and pencil questionnaires on coping during a session with her counsellor.

I am also of the understanding that my child's responses will remain **completely anonymous**, and she will not be identified at any stage of the project.

Signed ..... (Caregiver)

..... (Child)

Date .....

CD INVENTORY

YOUR NAME_____

YOUR DATE OF BIRTH _____

TODAY'S DATE _____

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group pick ONE sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this X next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you best.

Example:

|___| I read books all the time.

|___| I read books once in a while.

|___| I never read books.

Remember pick out the sentences that describe your feelings and ideas in the past two weeks.

1.	|____|	I am sad once in a while
	|____|	I am sad many times
	|____|	I am sad all the time
2.	|____|	Nothing will ever work out for me
	|____|	I am not sure if things will work out for me
	|____|	Things will work out for me O.K.
3.	|____|	I do most things O.K.
	|____|	I do many things wrong
	|____|	I do everything wrong.
4.	|____|	I have fun in many things.
	|____|	I have fun in some things.
	|____|	Nothing is fun at all
5.	|____|	I am bad all the time
	|____|	I am bad many times
	|____|	I am bad once in a while
6.	|____|	I think about bad things happening to me once in a while.
	|____|	I worry that bad things will happen to me
	|____|	I am sure that terrible things will happen to me.

7.	|____|	I hate myself	
	|____|	I do not like myself	
	|____|	I like myself.	
8.	|____|	All bad things are my fault	
	|____|	Many bad things are my fault	
	|____|	Bad things are not usually my fault	
9.	|____|	I do not think about killing myself	
	|____|	I think about killing myself but I would not do it	
	|____|	I want to kill myself.	
10.	|____|	I feel like crying everyday	
	|____|	I feel like crying many days	
	|____|	I feel like crying once in a while	
11.	|____|	Things bother me all the time	
	|____|	Things bother me many times	
	|____|	Things bother me once in a while	
12.	|____|	I like being with people	
	|____|	I do not like being with people many times	
	|____|	I do not want to be with people at all.	
13.	|____|	I cannot make up my mind about things	
	|____|	It is hard to make up my mind about things	
	|____|	I make up my mind about things easily.	

14.	|___|	I look O.K.	
	|___|	There are some bad things about my looks	
	|___|	I look ugly	
15.	|___|	I have to push myself all the time to do my schoolwork	
	|___|	I have to push myself many times to do my schoolwork.	
	|___|	Doing schoolwork is not a big problem	

Remember, describe how you have been in the past two weeks

16.	|___|	I have trouble sleeping every night	
	|___|	I have trouble sleeping many nights	
	|___|	I sleep pretty well	
17.	|___|	I am tired once in a while	
	|___|	I am tired many days	
	|___|	I am tired all the time	
18.	|___|	Most days I do not feel like eating	
	|___|	Many days I do not feel like eating	
	|___|	I eat pretty well	
19.	|___|	I do not worry about aches and pains	
	|___|	I worry about aches and pains many times	
	|___|	I worry about aches and pains all the time	

20.	|____|	I do not feel alone	
	|____|	I feel alone many times	
	|____|	I feel alone all the time	|_____
21.	|____|	I never have fun at school	
	|____|	I have fun at school only once in a while	
	|____|	I have fun at school many times	|_____
22.	|____|	I have plenty of friends	
	|____|	I have some friends but I wish I had more	
	|____|	I do not have any friends	|_____
23.	|____|	My school work is alright	
	|____|	My school work is not as good as before	
	|____|	I do very badly in subjects I used to be good in	|_____
24.	|____|	I can never be as good as other kids	
	|____|	I can be as good as other kids if I want to	
	|____|	I am just as good as other kids	|_____
25.	|____|	Nobody really loves me	
	|____|	I am not sure if anybody loves me	
	|____|	I am sure that somebody loves me	|_____
26.	|____|	I usually do what I am told	
	|____|	I do not do what I am told most times	
	|____|	I never do what I am told	|_____

27. |____| I get along with people

|____| I get into fights many times

|____| I get into fights all the time

The End

Thank you for filling out this form

WAYS OF COPING CHECKLIST

What to do: Below are some ways of thinking that children might use when faced with unexpected situations. Please circle the number on the scale (which goes from 0 to 3) that **matches your feelings and actions best** at the time you were being touched. Your answers to every question are imporant and will help other children who have been through similar situations.

What each number means:

0 = No (you did not think or do this when you were being touched)
1 = Only Sometimes (You thought or did this a little bit when you were being touched)
2 = Often (You thought or did this more than just sometimes when you were being touched)
3 = Almost all the Time (While you were being touched you thought or did this nearly always)

1. I tried to think about what was happening so it would make more sense to me.

   0_____1_____2_____3

2. I played alot or worked hard at school so I wouldn't have to think about it much.

   0_____1_____2_____3

3. I waited for him to finish/stop touching me.

   0_____1_____2_____3

4. I did something that I had a feeling might not work, but at least I was doing something.

   0_____1_____2_____3

5. I tried to tell him not to do this to me.

   0_____1_____2_____3

6. I talked to someone to see if it was happening to others as well, or if I was the only one.

   0_____1_____2_____3

7. I told myself off.

0_____1_____2_____3

8. I hoped a miracle would happen.

0_____1_____2_____3

9. I thought things happen because they're meant to, so this was meant to be.

0_____1_____2_____3

10. I went on with my life as if nothing was happening.

0_____1_____2_____3

11. I tried to keep my feelings to myself.

0_____1_____2_____3

12. I tried to look on the bright side of things 0_____1_____2_____3

I thought happy and nice thoughts 0_____1_____2_____3

13. I slept more.

0_____1_____2_____3

14. I got angry at the person who was touching me

0_____1_____2_____3

15. I took my anger out on him or others

0_____1_____2_____3

16. I made sure I was with kind people alot, who were good to me.

0_____1_____2_____3

17. I told myself things that helped me to feel better.

0_____1_____2_____3

18. I took my mind off it by drawing, playing, having imaginary friends.

0_____1_____2_____3

19. I tried to forget that it happened.

0_____1_____2_____3

20. I told someone what was happening.

0_____1_____2_____3

21. I thought to myself that I would be a stronger person because of this.

0_____1_____2_____3

22. I waited to see what would happen before doing anything.

0_____1_____2_____3

23. I did something to make up for what was happening.

0_____1_____2_____3

24. I made a plan of action and followed it.

0_____1_____2_____3

25. I let my feelings out somehow.

0_____1_____2_____3

26. I felt like I was somewhere else, and that this was not really happening to me.

0_____1_____2_____3

27. I thought to myself this is my fault - I brought it on myself

0_____1_____2_____3

28. I thought "If I can cope with this I can cope with anything".

0_____1_____2_____3

29. I tried to make myself better by eating more, smoking, drinking alcohol, taking pills.

0_____1_____2_____3

30. I did something risky - something I would not normally do.

0_____1_____2_____3

31. I prayed to God.

0_____1_____2_____3

32. I thought brave things.

0_____1_____2_____3

33. I thought about the things I really like doing.

0_____1_____2_____3

34. I did or changed something so things would turn out right.

0_____1_____2_____3

35. I stayed away from people/ was by myself a lot more.

0_____1_____2_____3

36. I didn't let it get to me - did not allow myself to think about it.

0_____1_____2_____3

37. I asked someone I trusted for advice.

0_____1_____2_____3

38. I thought of happy times.

0_____1_____2_____3

39. I thought of ways to get him back for what he was doing to me.

0_____1_____2_____3

40. I didn't let anyone know how bad things were.

0_____1_____2_____3

41. I did not think it was serious.

0_____1_____2_____3

42. I didn't let it happen often, I avoided the person who touched me. I kept away as much as I could

0_____1_____2_____3

43. I thought about someone I love.

0_____1_____2_____3

44. I thought about the last time it happened, and that I got through OK then.

0_____1_____2_____3

45. I refused to or did not want to believe that it had happened.

0_____1_____2_____3

46. I had my own special thoughts that helped me.

0_____1_____2_____3

47. I thought to myself, "this will not happen again".

0_____1_____2_____3

48. I came up with some answer or solution to the problem

0_____1_____2_____3

49. I accepted what was happening to me

0_____1_____2_____3

50. I didn't let my feelings get in the way of how I was at school or with friends.

0_____1_____2_____3

51. I wished I could change what had happened or how I felt.

0 1 2 3

52. I changed something about myself.

0_____1_____2_____3

53. I daydreamed or imagined a better place or time.

0_____1_____2_____3

54. I felt like it was happening to someone else.

0_____1_____2_____3

55. I wished that it would stop.

0_____1_____2_____3

56. I wished or imagined that things would turn out the way I wanted them to

0_____1_____2_____3

57. I prepared myself for the worst thing that could happen to me or my family.

0_____1_____2_____3

58. I went over in my mind what I would say or do, so it might stop.

0_____1_____2_____3

59. I thought about how a friend/ person / teacher who I really liked would handle it, if it happened to them.

0_____1_____2_____3

60. I did things with my body which helped (e.g., I clenched my fists, I closed my eyes, I held something).

0_____1_____2_____3

61. I tried to see things from his point of view.

0_____1_____2_____3

62. I thought things could be a lot worse.

0_____1_____2_____3

63. I exercised or played a lot of sport.

0_____1_____2_____3

64. I tried something different from the above. Please describe what other thoughts you had or things you did to make yourself feel a bit better:

.....

.....

.....

Now please answer Yes or No to the questions below:

65. I thought things like this happen to all children	Yes	No
66. I thought this was a normal part of growing up.	Yes	No
67. I thought I had done something wrong or bad.	Yes	No
68. I thought it was an accident, that he didn't mean to touch me.	Yes	No
69. I wondered what he was doing.	Yes	No
70. I was a little interested to see what would happen.	Yes	No
71. I thought what he was doing was yukky.	Yes	No
72. I never really loved him.	Yes	No
73. I thought it was OK	Yes	No
74. I thought he didn't mean to harm me in any way.	Yes	No
75. I thought he was showing me he loved me.	Yes	No
76. I thought something terrible would happen to me (e,g., get pregnant, get a disease, that my family would break up, or me or my family would get hurt)	Yes	No
77. I thought the way he touched me felt nice.	Yes	No
78. I thought that because he was my father/uncle/grand-dad, what he was doing must be right/OK.	Yes	No
79. I could not understand how he could do this to me.	Yes	No
80. I felt scared and worried.	Yes	No
81. Before he touched me, I loved him alot.	Yes	No
82. I thought he must be nuts to do this to me.	Yes	No
83. I think other people liked him a lot.	Yes	No
84. I think other people did not like him much.	Yes	No
85. I felt sorry for him.	Yes	No
86. I loved him, but didn't like what he was doing to me.	Yes	No
87. I did not ever like him.	Yes	No
88. I thought people would act differently towards me, I was worried they would.	Yes	No
89. For a long time, I could not believe this was		

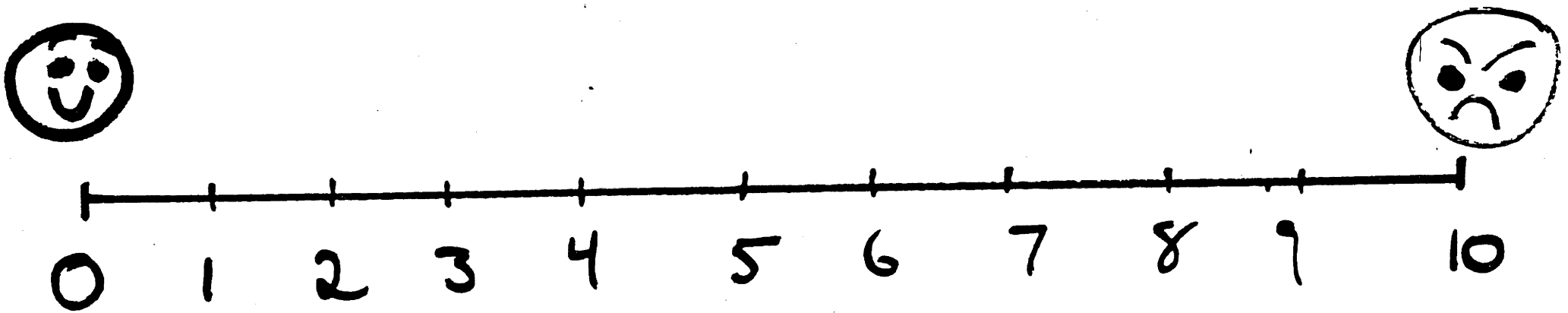
happening to me.	Yes	No
90. I thought I'd be better off dead.	Yes	No
91. I thought other people/children have gone through bad things and they get through alright/they seem to cope.	Yes	No
92. I thought I will never be the same again.	Yes	No
93. I thought to myself " I'm going to be OK".	Yes	No

STRESS MEASURE CARD

SUBJECT CODE NO

No Stress
Happy, Relaxed

Extreme Stress
Very Unhappy



You are almost finished! Please circle the number that best describes how you felt when you were being touched. Ask your counsellor to help you if you are not sure what the numbers mean.

THANK YOU for your help!

DEMOGRAPHIC AND HISTORICAL INFORMATION

*SUBJECT NO.:*_____

A. **CHILD**

1. Age: _____

2. Sex: _____

3. Current Residence: (e.g., home, foster, institutional care, who with etc.)

_____

_____

4. Number of siblings and sex of siblings:_____

_____

5. Do both parents work? Please specify part or full-time:_____

_____

B. **RELATIONSHIP BETWEEN OFFENDER AND CHILD:**

1. Who was the perpetrator: (e.g., father, neighbour etc.):

_____

2. Were the child and perpetrator living together at the time of abuse?

_____

3. Quality of perpetrator-child relationship:_____

_____

4. Child's current feelings about perpetrator:_____

_____

C. **ABUSE:**

1. Type of sexual abuse:_____

_____

2. Duration:_____

3. Frequency:_____

4. Type of coercion used by offender:_____

_____

5. Was physical abuse part of this child's environment?_____

If so, who perpetrated this?_____

D. **DISCLOSURE:**

1. When and how was the abuse disclosed ?_____

_____

2. Has the child attempted disclosure previously ?_____

If so, when and how ?_____

_____

3. How have Significant Others reacted to the recent disclosure?

_____

_____

4. Does the primary parent believe the child ?_____

5. How does the child currently feel about her disclosure ?

_____

_____

6. How has the disclosure affected the child's relatonship with her primary parent ?

_____

E. **SUPPORT:**

1. Did the child have supportive relationships with siblings or non-offending parent during the abusive period ?_____

_____

2. Who or what is the child's major source of support at the moment ?

3. Is the child's mother currently supporive ?_____

4. Does the child have satisfying relationships with either school peers or children her own age ?_____

5. Who has the child been speaking favourably about ? Does she mention some people more often than others ?_____

F. **THERAPY:**

1. How long after disclosure did the child begin therapy / counselling?

2. How many therapeutic sessions has the child had ?_____

3. What has been the focus of this child's therapy ?_____

4. How is the child progressing in therapy ? Please include child's behaviour and disposition, relationship with therapist and other noteable features which may be worthwhile to the project:

G. **PERPETRATOR OUTCOME:**

1. Briefly describe the child's experience in court :_____

2. Was the perpetrator prosecuted ?_____

How does the child feel about the outcome ?_____

3. Do the perpetrator and non-offending caregiver maintain contact - if so, how does the child feel about this ?_____

H. CHILD'S CASEWORKER'S ASSESSMENT OF IMPACT:

1. Please list noteable features of the child's behaviour, disposition, school performance, socal interactions and sleep pattern, that the child and/or parent have described as being present

(a) **During the abusive period:**_____

_____

_____

_____

(b) **After disclosure and any legal proceedings:**_____

_____

_____

_____

Thankyou

(2) CONTROL GROUP

INSTRUCTIONS TO CHILDREN AND THEIR PARENTS PARTICIPATING IN THE "WAYS OF COPING" STUDY

Your instructions:

First of all, I would like to thank you for helping out in an important study on how children in Australia deal with stress - i.e., how they cope with the times they are faced with worrying or concerning situations. By helping out, you are enabling children who have experienced quite difficult problems to cope better.
Inside your yellow envelope there are 2 questionnaires for you to fill out. Please read through the instructions on both questionnaires before starting.

1) Do the "CD Inventory" first, then
2) the "Ways of Coping Checklist".

The last page of the Coping Checklist has a large scale with 2 different faces. Please circle the number that best applied to you when you were dealing with the tough time. When you have finished, put the questionnaires back in the large stamped envelope with my name and address on it and mail back to me. It is really important that you do this before **Friday, 10 September.** If you have any questions, ask your mum or dad to help out, as I have given them instructions too!

Yout Parent's instructions:

Thank you for your interest and time in helping out with the study on coping strategies used by children. Your child's responses will be very helpful, and will remain completely anonymous and confidential.
Enclosed in the envelope you have received are:
1) Consent forms - please fill in.
2) Two questionnaires (see above) for your child to complete
3) One questionnaire for you to complete, "Background Information"
4) Stamped self-addressed A4 envelope to return all questionnaires in.
Please set aside approximately an hour and a quarter with your child in a quiet room, free from distractions. With your child, read through the instructions on both questionnaires, making sure that he or she understands what to do. Please remain with your child for 10 minutes while he or she begins answering the CD Inventory (this is followed by the Ways of Coping Checklist). It is preferable that your child completes the questionnaires on his/her own, alone. However, should he/she request that you remain, please do so (making a note of this on the questionnaire when they have finished). **Please ensure that completed questionnaires are posted prior to Friday 10 September.**

Once again, thank you for your participation.

Zina Kaleniuk
16 August 1993

WAYS OF COPING CHECKLIST

What to do: Below are some ways of thinking that children might use when faced with unexpected, difficult or worrying situations. Please circle the number on the scale (which goes from 0 to 3) that **matches your feelings and actions best** at a time in your life in the **last one and a half years** that was difficult or worrying. Your answers to every question are important and will help other children who have been through some very difficult situations. Before you start can you please briefly write down what the situation was (it can be a big or a small worry, as long as ***you*** felt that it was a pretty difficult time for you):

_____

_____

_____

_____

_____

What each number on the scale means:

0 = No (you did not think or do this)
1 = Only Sometimes (You thought or did this a little bit)
2 = Often (You thought or did this more than just sometimes)
3 = Almost all the Time (You thought or did this nearly always)

1. I tried to think about what was happening so it would make more sense to me.

   0_____1_____2_____3

2. I played alot or worked hard at school so I wouldn't have to think about it much.

   0_____1_____2_____3

3. I waited for the problem to go away.

   0_____1_____2_____3

4. I did something that I had a feeling might not work, but at least I was doing something.

   0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

5. I tried to get the people who were responsible to change their mind(s)

0_____1_____2_____3

6. I talked to someone to find out more about what was happening.

0_____1_____2_____3

7. I told myself off.

0_____1_____2_____3

8. I hoped a miracle would happen.

0_____1_____2_____3

9. I thought things happen because they're meant to, so this was meant to be.

0_____1_____2_____3

10. I went on with my life as if nothing was happening.

0_____1_____2_____3

11. I tried to keep my feelings to myself.

0_____1_____2_____3

12. I tried to look on the bright side of things 0_____1_____2_____3

I thought happy and nice thoughts 0_____1_____2_____3

13. I slept more.

0_____1_____2_____3

14. I got angry at the person who I thought was to blame for the problem

0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

15. I took my anger out on that person.

0_____1_____2_____3

16. I made sure I was with kind people alot, who were good to me.

0_____1_____2_____3

17. I told myself things that helped me to feel better.

0_____1_____2_____3

18. I took my mind off it by drawing, playing, having imaginary friends, listening or playing to music.

0_____1_____2_____3

19. I tried to forget that it happened.

0_____1_____2_____3

20. I told someone what was happening.

0_____1_____2_____3

21. I thought to myself that I would be a stronger person because of this.

0_____1_____2_____3

22. I waited to see what would happen before doing anything.

0_____1_____2_____3

23. I did something to make up for what was happening.

0_____1_____2_____3

24. I made a plan of action and followed it.

0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

25. I let my feelings out somehow.

0_____1_____2_____3

26. I felt like I was somewhere else, and that this was not really happening to me.

0_____1_____2_____3

27. I thought to myself this is my fault - I brought it on myself

0_____1_____2_____3

28. I thought "If I can cope with this I can cope with anything".

0_____1_____2_____3

29. I tried to make myself better by eating more, smoking, drinking alcohol, taking pills.

0_____1_____2_____3

30. I did something risky - something I would not normally do.

0_____1_____2_____3

31. I prayed to God.

0_____1_____2_____3

32. I thought brave things.

0_____1_____2_____3

33. I thought about the things I really like doing.

0_____1_____2_____3

34. I did or changed something so things would turn out right.

0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

35. I stayed away from people/ was by myself a lot more.

0_____1_____2_____3

36. I didn't let it get to me - did not allow myself to think about it.

0_____1_____2_____3

37. I asked someone I trusted for advice.

0_____1_____2_____3

38. I thought of happy times.

0_____1_____2_____3

39. I thought of ways to get the person back for what was happening.

0_____1_____2_____3

40. I didn't let anyone know how bad things were.

0_____1_____2_____3

41. I did not think it was serious.

0_____1_____2_____3

42. I knew what I could do to make things good, so I tried very hard to make things work out well again.

0_____1_____2_____3

0 = No (you did not think or do this)
1 = Only Sometimes (You thought or did this a little bit)
2 = Often (You thought or did this more than just sometimes)
3 = Almost all the Time (You thought or did this nearly always)

43. I thought about someone I love.

0_____1_____2_____3

44. I thought about the last time it happened, and that I got through OK then.

0_____1_____2_____3

45. I refused to or did not want to believe what was happening.

0_____1_____2_____3

46. I had my own special thoughts that helped me.

0_____1_____2_____3

47. I thought to myself, "this will not happen again".

0_____1_____2_____3

48. I came up with some answer or solution to the problem

0_____1_____2_____3

49. I accepted what was happening to me

0_____1_____2_____3

50. I didn't let my feelings get in the way of how I was at school or with friends.

0_____1_____2_____3

51. I wished I could change what had happened or how I felt.

0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

52. I changed something about myself.

0_____1_____2_____3

53. I daydreamed or imagined a better place or time.

0_____1_____2_____3

54. I felt like it was happening to someone else.

0_____1_____2_____3

55. I wished that the problem would stop.

0_____1_____2_____3

56. I wished or imagined that things would turn out the way I wanted them to

0_____1_____2_____3

57. I prepared myself for the worst thing that could possibly happen to me or my family.

0_____1_____2_____3

58. I went over in my mind what I would say or do, so it might stop.

0_____1_____2_____3

59. I thought about how a friend/ person / teacher who I really liked would handle it, if it happened to them.

0_____1_____2_____3

60. I did things with my body which helped (e.g., I clenched my fists, I closed my eyes, I held something).

0_____1_____2_____3

0 = **No** (you did not think or do this)
1 = **Only Sometimes** (You thought or did this a little bit)
2 = **Often** (You thought or did this more than just sometimes)
3 = **Almost all the Time** (You thought or did this nearly always)

61. I tried to see things from another person's point of view.

0_____1_____2_____3

62. I thought things could be a lot worse.

0_____1_____2_____3

63. I exercised or played a lot of sport.

0_____1_____2_____3

64. I tried something different from the above. Please describe what other thoughts you had or things you did to make yourself feel a bit better:

.....

.....

.....

Now please answer Yes or No to the questions below (still about the same situation that caused you a bit or a lot of worry):

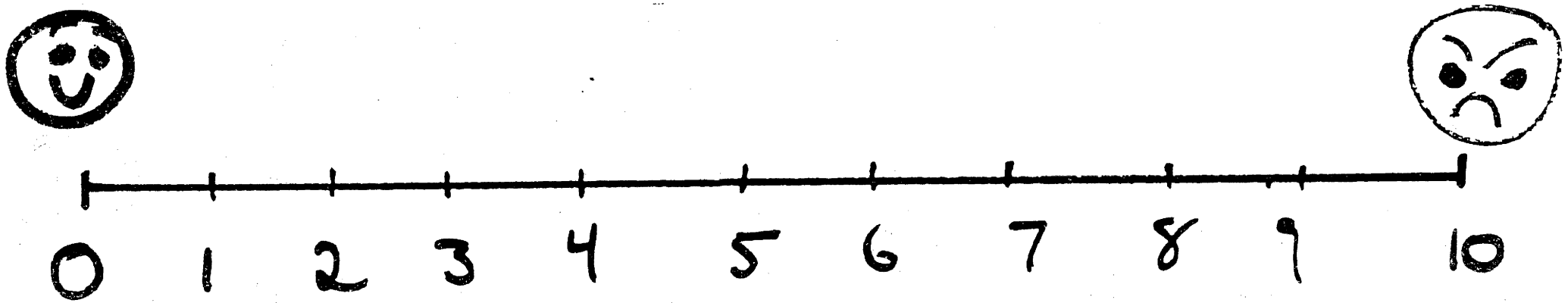
1. I thought that what was happening was a normal part of growing up. Yes No
2. I thought I had done something wrong or bad. Yes No
3. I was a little interested to see what would happen. Yes No
4. I was scared and worried. Yes No
5. I thought that something terrible would happen to me or my family. Yes No
6. I was a little worried about what other people would think about me. Yes No
7. For a long time, I could not believe this was happening to me. Yes No
8. I did not like what was happening at all. Yes No
9. I wished I would wake up and it would all be over. Yes No
10. I thought to myself, I am going to be O.K. Yes No

STRESS RELEASE CARDS

SUBJECT CODE NO

No Stress
Happy, Relaxed

Extreme Stress
Very Unhappy



You are almost finished! Please circle the number that best describes how you felt during the difficult time. Ask your parents to help you if you are not sure what the numbers mean.

THANK YOU for your help!

To be completed by the child's parent

BACKGROUND INFORMATION

1. Your child's age: _____

2. Your child's gender:_____

3. Who lives in the family home: (eg., mother, grandfather, 1 daughter) _____

_____

4. Do you work? Please specify F/T, P/T or casual _____

5. Does your spouse work? F/T, P/T or casual _____

6. If you no longer live with your spouse, how does your child get along with the parent who lives away from home? _____

7. How does your child cope with daily "hassles"? _____

_____

8. Do you think your child has experienced stressors in the last 18 months? Please describe the nature of the stressor(s) _____

_____

_____

9. How do you feel that your child has coped with the above stressor(s)?

_____

_____

_____

10. Who or what are the child's major support when big or small problems occur in his/her life?_____

_____

11. How is your child progressing at school? (e.g., include peer relationships, academic performance)_____

_____

Thankyou.

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